Senate Budget & Fiscal Review

Senator Wesley Chesbro, Chair

Subcommittee No. 3
on
Health, Human Services, Labor, & Veterans Affairs

Senator Wesley Chesbro, Chair
Senator Gilbert Cedillo
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Senator Deborah Ortiz

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Upon Adornment of Session

Room 4203

MAY REVISION & OPEN ISSUES

Item	*Description*
4120	**Emergency Medical Services Authority (EMSA)**
4280	**Managed Risk Medical Insurance Board (MRMIB)**
4260	**Department of Health Services—Public Health & Medi-Cal**
4440	**Department of Mental Health**

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I. ITEMS RECOMMENDED FOR "VOTE ONLY" *(Shown by Department)* *(Items "A" Through "E")*

A. EMERGENCY MEDICAL SERVICES AUTHORITY
(Vote Only Calendar)

1. Restoration of the EMSA—Governor Rescinds Proposal

Subcommittee's Prior Action: In its April 28th hearing, **the Subcommittee *rejected* the Governor's January proposal to transfer the EMSA to the DHS, and instead (1) reduced the EMSA support budget by the same level of savings--$138,000 (General Fund)—as proposed through the consolidation, and (2) adopted corresponding Budget Bill Language.**

The suggested language is as follows:

Item 4120-001-0001 Provision 1.
It is the Legislature's intent for any reduction taken in this item to be obtained from state support only and not local assistance. This may include efficiencies and savings obtained from personnel expenditures, operating expenditures or equipment.

Governor's May Revision: The Governor's May Revision rescinds the proposed January consolidation and also deletes $138,000 (General Fund) from EMSA state support. **As such, the proposal is identical to the Subcommittee's prior action, *except* for the Budget Bill Language.**

Subcommittee Staff Comment: **It is suggested to retain the Subcommittee's prior action of April 28th, including the Budget Bill Language.** The Budget Bill Language clarifies the Legislature's intent that the reduction come only from state support and not any local assistance.

2. Hospital Bioterrorism Preparedness Program—*Will Conform to DHS Item*

Background—Overall Summary: The Emergency Supplemental Appropriations for Recovery & Response to Terrorist Attacks on the US Act (Public Law 107-117 of 2002), and subsequent federal legislation, among many other things, **provided states with additional federal funds to support and address both local and state concerns regarding the threat of bioterrorism.**

Under the *initial* supplemental grant award in 2002, there were two funding streams made available to California—one from the federal Centers for Disease Control (CDC) and the other from the federal HRSA for the development and implementation of regional plans to improve the capacity of hospitals, their emergency departments, outpatient centers, emergency medical systems and related matters.

California's *new* 12-month cycle (August 31, 2003 through August 30, 2004) **is $94.4 million (federal funds), of which $55.6 million is from the federal CDC and $38.8 million is from**

HRSA. However for state budgeting purposes, only ten months of the federal fiscal year is captured. Therefore, this allocation will cross over two state fiscal years.

Governor's May Revision: The May Revision proposes that the $32.8 million from HRSA for local grants to upgrade the preparedness of the State's hospitals and local health care organizations for a biological attack be appropriated to the DHS and transferred to the EMSA to be expended, as was done last year. **The EMSA will then award local grants to hospitals, local emergency medical service agencies, and other qualified health care organizations for bioterrorism planning and preparedness activities.**

Subcommittee Staff Recommendation: The entire May Revision proposal regarding expenditure of the federal Bioterriorism funds—to be appropriated to the DHS—is to be discussed below, under the DHS-public health item. **As such, it is recommended to have this EMSA item simply conform to the action taken under the DHS item.**

Budget Issue: Does the Subcommittee want to have the EMSA action conform to the DHS action—the department actually appropriating the funds?

B. MANAGED RISK MEDICAL INSURANCE BOARD *(Vote Only Calendar)*

1. Technical Trailer Bill Legislation Adjustment—AIM Merger

Background: In the Administration's trailer bill legislation that accompanied the AIM merger with Healthy Families proposal, as discussed in the March 3rd, 2003, Subcommittee hearing, there is a technical drafting error in the language (RN0301034).

Specifically, please delete Section 11, pages 18-20 (Insurance Code Section 12693.41); this will reinstate current (inoperative) law. On page 19, in subdivision (b), the Administration had added a new cross-reference to the AIM babies who will be shifting into Healthy Families starting in 2004-05. However, this cross-reference is moot, since the whole section is already inoperative (as of 4/1/03) and will be repealed on 1/1/04. There are two versions of Section 12693.41, and the one that just became operative on 4/1/03 does not contain the subdivision (b) language. Therefore, no cross-reference is needed.

Subcommittee Staff Recommendation: It is recommended to adopt this technical correction to the language.

Budget Issue: Does the Subcommittee want to **adopt this technical correction?**

2. Technical Adjustment Due to Tobacco Settlement Funds—Healthy Families

Background-- Finance Letter and Interaction with May Revision: The Governor's January budget assumed that $220 million (Tobacco Settlement Funds) would be available in 2003-04 for the Healthy Families Program (HFP). **However, when the Administration changed the structure and sizing of the anticipated Tobacco Settlement Funds securitization, it was determined by the Department of Finance that the $220 million in funds would no longer be available in the budget year for the HFP. As such, the DOF submitted a Finance Letter to the Legislature requesting $220 million in General Fund support to backfill for the loss in Tobacco Settlement Funds.**

However, since this Finance Letter was submitted (i.e., April), the DOF notes that the market conditions regarding the securitization of the bond has changed, so the Governor's May Revision proposes not to securitize the remaining Tobacco Settlement Fund revenues. This aspect of the Governor's May Revision is captured in the Healthy Families Program estimates package (regarding caseload and related adjustments).

Subcommittee Staff Recommendation: In order **to achieve technical budgeting clarity due to the DOF's Change Book system, it is recommended for the Subcommittee to adopt the Finance Letter, and then to adopt the May Revision estimate package regarding the Healthy Families Program** ***(to be discussed below under MRMIB—Discussion Items).***

The net affect of these two actions are as follows:

• Finance Letter	**$220 million (increased GF)**	$220 million (decrease Tobacco Settlement)
• May Revision	**$173.4 million (decrease GF)**	$173.4 million (increase Tobacco Settlement)
• **Net**	**$ 46.6 million (increase GF)**	$46.6 million (decrease Tobacco Settlement)

Budget Issue: Does the **Subcommittee want to adopt the Finance Letter** and then discuss the May Revision HFP estimate below (where adjustments will be made to net the General Fund)?

3. Healthy Families Program—Restore Rural Demonstration Projects

Background: The **Rural Health Demonstration Projects, enacted into law in 1997 as part of the original enabling HFP legislation for children, are vital projects and have been used to develop and enhance existing health care delivery networks for special populations and to address geographic access barriers.** These projects are an integral component of the Healthy Families Program.

Specifically, the funds have been used **to extend community clinic hours, expand telemedicine applications, provide bilingual specialty health care services, provide mobile medical services and dental services, and rate enhancements to increase HFP provider networks in**

remote areas. According the Rural Demonstration Project 2002 Fact Book, over 238 projects have been funded with very successful and measurable results.

The enabling legislation for Rural Health Demonstration Projects contained a sunset clause, as did the Healthy Families Program overall. Specifically, the statute is set to sunset as

Budget Act of 2002: **The Legislature restored a total of $4.8 million ($1 million General Fund, $683,000 Tobacco Settlement Funds and $3.2 million federal funds) for the Rural Demonstration Projects funded under the MRMIB, and the Governor sustained the adjustment.**

Governor's January Budget & May Revision: The January budget proposed to eliminate the Rural Demonstration Projects funds used in the HFP for savings of $4.8 million ($1.7 million General Fund and $3.1 million federal Title XXI funds). **The May Revision did not restore this proposed elimination.**

According to the MRMIB, the only reason these projects are being deleted is due to General Fund constraints.

Subcommittee Staff Recommendation: Subcommittee staff **recommends to shift $1.047 million in Propositions 99 Funds from the Office of Statewide Health Planning and Development (OSHPD) and the Rural Health Grants Program to the Managed Risk Medical Insurance Board and the HFP to assist in funding the Rural Demonstration Projects. This shift will enable the state to obtain a 65 percent federal match using Title XXI funds.**

In addition, in order to obtain a federal Title XXI match, **it is also recommended to adopt placeholder trailer bill language which would enable Proposition 99 funds to be used to obtain a federal match specifically for the Rural Demonstration Projects.** If place holder trailer bill language is not adopted, then a federal match cannot be obtained. Due to the structure of Proposition 99, a four-fifths vote of the Legislature is required for passage in order to obtain the federal funds. **Further**, it is recommended **to repeal the sunset for the projects, authorize the MRMIB to perform these activities, and require implementation of the projects upon an appropriation in the annual Budget Act or other statute.**

Budget Issue: Does the **Subcommittee want to adopt** the following actions: **(1)** delete the $1.047 million (Proposition 99 Funds) from the Rural Health Grants and shift the funds to the Rural Health Demonstration Projects in the HFP, along with a corresponding 65 percent Title XXI match, and **(2)** repeal the sunset date for the projects.

C. DEPARTMENT OF HEALTH SERVICES *(Vote Only Calendar)*

1. Childhood Lead Program Reappropriation for RASSCLE II

Governor's May Revision: The Response and Surveillance System for Childhood Lead Exposures (RASSCLE) system was initially approved in the Budget Act of 2001 from the Childhood Lead Poisoning Prevention Fee Fund. **However, funds were reappropriated in 2002-03 because new information technology requirements were introduced in 2001-02 that delayed the project.**

According to the DHS, they have made considerable progress on the project by completing project planning and requirements gathering. They state that they are ready to begin the software development and system implementation phase but have been faced with a new two-fold increase in time to release and procure the development contract Request for Proposal. **As a result, they contend that the best way to proceed is to develop the RASSCLE system utilizing in-house development staff, while augmenting required skills through a mentoring contract. Using this approach, the DHS states that the project will end by November 15, 2004.**

The approved project funds in 2002-03 were $1.217 million. Since this year's procurement delays, only $173,995 will be expended leaving $1,043,208 (special fund—Childhood Lead Poisoning Prevention Fee Fund) in unexpended project funds. As such, the May Revision is requesting to re-appropriate this amount in Item 4260-001-080.

Subcommittee Staff Recommendation: Development of the RASSCLE is important in California's efforts for mitigating childhood lead poisoning since state and local health agencies use RASSCLE for childhood lead poisoning surveillance and case management activities. As such, it is recommended to proceed with the proposed re-appropriation.

Budget Issue: Does the Subcommittee **want to adopt the May Revision?**

2. Alzheimer's Disease and Related Disorders Research Fund

Background and Governor's May Revision: In California, there are over 500,000 Alzheimer's patients. The total costs of caring for this disease are estimated at between $10 billion and $20 billion per year in California. It has a profound impact not only on the person with the disease, but also on the families, caregivers and medical care system.

The Alzheimer's Disease and Related Disorders Research (ADRDR) Fund generates funds through voluntary contributions (tax check-off) of state taxpayers for the specific purpose of funding research projects for Alzheimer's disease and related disorders.

The May Revision requests an increase of $450,000 (ADRDR Fund) to support more research projects which may develop and advance the understanding, techniques and modalities effective in the cure of Alzheimer's disease. This adjustment would increase the budget authority to a

total of $742,000 (ADRDR Fund). The balance of the ADRDR Fund is nearly $1.3 million, so the funds are available for expenditure.

Subcommittee Staff Recommendation: Subcommittee staff recommends that the Subcommittee **adopt** the proposal.

Budget Issue: Does the Subcommittee **want to adopt the May Revision proposal?**

3. East End Rent Adjustments

Background: In the Spring of 2003, the California Department of Education (CDE) informed the Department of General Services (DGS) that they no longer desired newly constructed office space within the East End project (located at the east end of the State Capitol)—specifically, Building 172. As such, the DOF and DGS proposed that the DHS occupy this space (Building 172) since the DHS has moved into Buildings 171, 173 and 174.

Governor's May Revision: The DHS **is requesting an increase of $625,000 ($231,000 General Fund**, $156,000 Radiation Control Fund and $238,000 federal funds) **in order to fund the increased facility space costs of occupying Building 172**, since the CDE will not. The DHS states that programs to move into this new space include Audits and Investigations, Payment Systems Division, Radiologic Health, the Office of HIPAA, and Emergency Preparedness.

Subcommittee Staff Recommendation: The DOF, DGS and DHS decision to have the DHS utilize Building 172, in lieu of the CDE, is certainly within the purview of the Administration. **However, providing additional General Fund support for increased rent expenditures due to the move at this time is not recommended due to the present deficiency.** The special funds—Radiologic Control Fund and federal funds—could be provided since these funding sources have available reserves.

Budget Issue: Does the Subcommittee **want to modify the May Revision request by (1) providing a total of $394,000** ($156,000 Radiologic Control Fund, and $238,000 federal funds) to fund a portion of the increased rent costs, **(2) rejecting** the $231,000 in General Fund support, and **(3)** directing the DHS to absorb the General Fund amount?

4. Convert Contract Nurse Positions to Civil Service for General Fund Savings

Background and Governor's May Revision: The DHS is requesting **(1)** the conversion of 71 contract nurse positions to permanent, full-time state civil service Nurse Evaluator II positions, and **(2)** to establish two permanent, full-time positions to provide oversight and support. The DHS is requesting for the **73 positions to be effective January 1, 2004** in order to provide the DHS with time to establish and fill the positions. The positions are currently under the direction of the state's Medi-Cal Fiscal Intermediary—Electronic Data Systems (EDS). These positions pertain to the Medical Case Management Program, Treatment Authorization Request utilization reviews conducted in Medi-Cal Field Offices, and appeals/litigation functions. .

The DHS states that the Administration will provide freeze exemptions to recruit and hire the staff.

The fiscal effect of this transaction will save the state General Fund support. Specifically, the Medi-Cal estimate for the Fiscal Intermediary contract is to be reduced by $4.2 million ($1 million General Fund for the budget year, and by $8.4 million ($2.1 million General Fund) in 2004-05 (annual basis). The DHS state support item will be increased by $3.5 million ($885,000 General Fund) in the budget year, and by $6.9 million ($1.7 million General Fund) in 2004-05 (annual basis). **This will result in a net savings of $120,000 General Fund for the budget year, and about $400,000 General Fund for 2004-05 (annual basis).**

Subcommittee Staff Recommendation: It is recommended **to adopt the proposal.**

Budget Issue: Does the Subcommittee want **to adopt the May Revision?**

5. Reversion of Unexpended Tobacco Settlement Funds to General Fund for Offset

Background and Governor's May Revision: Based on updated expenditure projections for the Child Health Disability Prevention (CHDP) Program for the current year (2002-03), the DHS states that there will be $6.0 million in unexpended funds from the Tobacco Settlement Fund.

As such, the May Revision proposes to transfer this $6 million from the Tobacco Settlement Fund to the General Fund to serve as an offset in expenditures. In order to technically effectuate this transfer, it is recommended to add Item 4260-010-3020 to the Budget Bill, as follows:

> 4260-010-3020—For Transfer by the Controller, from the Tobacco Settlement Fund, to the General Fund……..$(6,000,000)

Subcommittee Staff Recommendation: It is recommended **to adopt the May Revision.**

Budget Issue: Does the Subcommittee want **to adopt the May Revision?**

6. Suspension of Local Mandates

Background: Chapter 268—SIDS Contacts by Local Health Officers—requires the State Controller to reimburse each local health officer for their mandated contact with the person who has caring for a victim of SIDS at the time of death to inform them of the nature and causes of SIDS and provide support, referral and follow services.

Chapter 453—SIDS Notices—requires coroners to notify the local health officer within 24 hours of a presumed death by SIDS. The local health officer must immediately contact the parent of the decreased to provide support, referral, information, and follow up services.

Both of these local mandates were suspended in the Budget Act of 2002.

Governor's May Revision: The May Revision proposes to decrease by $2,000 to reflect the suspension of two mandates—Sudden Infant Death Syndrome (SIDS) contracts by Local Health Officers (Chapter 268, Statutes of 1991), and SIDS notices (Chapter 453, Statutes of 1974). **In order to effectuate this proposal, the following Budget Bill Language is required:**

> Item 4260-295-0001
> Pursuant to Section 17581 of the Government Code, mandates identified in the appropriation schedule of this item with an appropriation of $0 and included in the language of this provision are specifically identified by the Legislature for suspension during the 2003-04 fiscal year:
>
> (1) SIDS Contracts by Local Health Officers (Chapter 268, Statutes of 1991)
> (2) SIDS Notices (Chapter 453, Statutes of 1974)

Budget Issue: Does the Subcommittee want **to adopt the May Revision?**

7. Proposed Reduction to the Expanded Access to Primary Care Clinics Program

Background: The purpose of the Expanded Access to Primary Care Clinic Program (EAPC) is to expand access to primary and preventative health care for the uninsured and medically underserved Californians. The program was created in 1989. Community-based clinics provide a high quality of care and are noted for being very cost-beneficial in their service delivery model.

Governor's May Revision: The May Revision **reduces by $2.350 million (General Fund) simply to reflect a reduction to the program in lieu of the Governor's Realignment proposal.**

Subcommittee Staff Recommendation: The May Revision reduction reflects an ad hoc reduction that has no policy basis. As such, it is recommended to reject the May Revision proposal.

Budget Issue: Does the Subcommittee **want to reject the May Revision proposal?**

8. Proposed Reduction to the Adolescent Family Life Program (AFLP)

Background: The AFLP was developed as a "best practice" model for reducing health, social, and economic costs related to adolescent pregnancy and parenting. AFLP originated as a federal pilot project in 1982 and was established as a Governor's initiative in 1985. Legislation passed in 1988 making it a permanent statutory program.

It provides counseling, education and support services for pregnant and parenting teens, including fathers, and their infants. The program also supports the development of projects that evaluate and refine effective models of practice in the areas of health behavior modification, prenatal care outreach, prevention, and the role of men in parenting.

Governor's May Revision: The May Revision **proposes to reduce by $1.621 million (General Fund) to reflect a reduction to the program in lieu of realignment.**

Subcommittee Staff Recommendation: The May Revision reduction reflects an ad hoc reduction that has no policy basis. As such, it is recommended to reject the May Revision proposal. Several program evaluations over the years have shown its efficacy.

Budget Issue: Does the Subcommittee **want to reject the May Revision proposal?**

9. "Medi-Cal to Healthy Families Program--Bridge" for Children Moving Between Programs *(Trailer Bill Item)*

Background: Historically, **a one-month "bridge"** has been provided **between the Medi-Cal and HFP programs for children, *and* a two-month bridge has been provided between the HFP and Medi-Cal**. As a families income rises or falls, children can continue to receive health care coverage as they transition to the other program, pending eligibility determination and plan transfer, when applicable.

In the omnibus health trailer bill (AB 430) which accompanied the Budget Act of 2001, statute was changed to provide for a **two-month bridge** between programs as part of the state's HFP Parental Expansion Waiver. However, even though the Waiver was approved by the federal government, **the two-month bridge (from Medi-Cal to the HFP) has never been implemented because funding for the Waiver expansion has not yet been appropriated.**

The two-month bridge (from HFP to Medi-Cal) has been in operation. This **bridge** takes effect when the HFP determines at annual eligibility review that the family's income qualifies the child for no-cost Medi-Cal coverage.

Governor's January Budget and May Revision: In their January trailer bill language, the Administration proposed trailer bill language to change the two-month provision to a one-month provision. **In addition, the Administration also proposed to insert an implementation date of October 1, 2006 for the one-month bridge (Medi-Cal to HFP) to change to two months.** The Administration is suggesting this subparagraph language for it would correspond with their

concept of when funding may be available for the Waiver and parental expansion. **This language continues to be proposed in their May Revision package.**

Prior Subcommittee Hearing: In the **March 3rd hearing**, this issue was discussed and the Subcommittee expressed interest in modifying the proposed trailer bill language as shown below under the Subcommittee staff recommendation.

Subcommittee Staff Recommendation: It is recommended **to modify the Administration's language by modifying subparagraph j. The revised suggested language is as follows:**

> (j) The one month of benefits provided in this section shall be increased to two months commencing upon implementation of the waiver as referenced in Section 12693.755.

The one-month reference would be used to replace the two-month reference in the other sections as noted. This would reflect existing funding and practice as the bridge pertains to going from Medi-Cal to the HFP.

In addition, the existing practice of having a two-month bridge in going from the HFP to Medi-Cal would remain. Funds are included in the Governor's budget for this purpose.

Budget Issue: Does the **Subcommittee want to adopt the modification to the trailer bill language as referenced above?**

10. Continuous Skilled Nursing Care Pilot Project (AB 359, Statutes of 1999)--Technical

Background and Governor's January Budget: This legislation required the DHS to establish **a Waiver pilot program** (up to ten sites) **to explore more flexible models of health care facility licensure to provide continuous skilled nursing care to medically fragile developmentally disabled individuals in the least restrictive environment.** Current licensing categories do not provide the flexibility to allow these individuals to reside in small, non-institutional health facilities.

This ICF/DD-CN pilot program began enrolling recipients on April 3, 2002. The pilots have an expiration date of January 1, 2006. The DHS was provided positions for the implementation, monitoring and evaluation of the pilot. These positions are slated to expire. **As such, the Governor's January budget proposed to extend the four positions, and to provide for an independent assessment (as required by federal law) for expenditures of $614,000 (total funds). Of this amount, $250,000 (total funds) was for the independent assessment.**

Prior Subcommittee Hearing: In the April 28th hearing, **the Subcommittee approved the DHS request for the positions, but suggested that the independent assessment could be conducted by the DOF (they have done several of these for other Waivers) at a substantial cost savings.**

Subcommittee Staff Recommendation: Since the hearing, Subcommittee staff has been informed that the evaluation will not be needed until 2004-05. **Therefore, it is recommended**

to delete the $250,000 (total funds) that had been budgeted in the Governor's January budget for this purpose.

Budget Issue: Does the Subcommittee **want to delete the $250,000 (total funds) for the evaluation since it is not needed until 2004-05?**

11. SB 26 (X)—Actions To Reflect Legislation

Background: SB 26(X), Statutes of 2002, ***among other things*****, contained statutory changes identified to reflect the following General Fund savings in the Medi-Cal local assistance budget:**

- County Performance Standards — $194 million General Fund savings
- Semi-Annual Reporting — $42.5 million General Fund savings
- Denti-Cal Program Savings — $50 million General Fund savings

Subcommittee Staff Recommendation: For the purpose of developing the Senate version of the Budget Bill, it is recommended to reflect the above adjustments in the May Revision proposal in order to capture the identified savings levels. It is recommended to direct the DOF to make all necessary Change Book adjustments.

Budget Issue: The Subcommittee directs the **DOF to reflect the savings identified in SB 26(X) as noted above for purposes of crafting the Senate budget bill.**

12. Licensing and Certification Fee Restructuring Proposal by the Administration

Background: Licensing and Certification functions conducted by the state are either fee-supported or reimbursed by the federal government (Title XIX funds—Medi-Cal). Existing law (Section 1266 of H&S Code) provides that health care facilities (hospitals and nursing facilities), except for those owned by public entities, are to pay an annual per-bed license fee.

This per-bed fee is calculated by the DHS based on the amount of license fee revenues needed to fund *current-year* spending (not budget year) for the regulatory and licensing and certification enforcement program. The proposed fee level is then reviewed by the Legislature through the annual budget process. Since public entities are statutorily exempt from paying licensing fees and those costs are not covered by other licensees, the General Fund must pay the difference.

Governor's January Budget: The Administration proposed two changes to the existing method used to calculate the licensing and certification fees. These two proposed trailer bill language changes will result in savings of about $5.8 million (General Fund).

First, they are proposing to **change the way fees are *calculated*** for health care facilities. **Current methodology** calculates the fee for facilities by dividing the total expenditures by the total number of beds in all facilities **(both public and private)**. The proposed change would

calculate the fee by dividing the total expenditures by the number of *private beds only*. As such, the non-exempt health facilities will cover the difference; thereby saving General Fund expenditures. The Administration states that savings of $4.7 million (General Fund) will be achieved by this particular change.

Second, the Administration is proposing to change from the existing process of calculating the upcoming budget year needs based on current year (i.e., 2002-03) expenditures to basing it on anticipated 2003-04 expenditures. Historically, any new funding proposals would be floated by the General Fund for one year before the fees would be adjusted the following year to include the added resources. Under the Administration's proposed change, the fees would be based on *estimated* actual needs in the budget year (2003-04) thereby eliminating any dependence on the General Fund to float resources. The Administration states that savings of just over $1 million (General Fund) will be achieved by this particular change.

Prior Subcommittee Hearing: In a prior hearing (April 28th), the Subcommittee heard public testimony and took the proposal under advisement.

Subcommittee Staff Recommendation: It is recommended to adopt the Administration's proposal.

Budget Issue: Does the Subcommittee want to **adopt** the Administration's proposal?

13. Medi-Cal Administrative Activities Program Claiming Plans

Background and Governor's May Revision: The objective of the Medi-Cal Administrative Activities (MAA) Program for schools and counties is to provide federal reimbursement for costs conducted to perform certain administrative activities necessary for the effective administration of the Medi-Cal Program, including:

- Outreach to individuals and families potentially eligible for Medi-Cal;
- Assisting individuals/families in the Medi-Cal application process;
- Arranging and providing non-emergency, non-medical transportation for Medi-Cal eligible individuals to and from providers of necessary Medi-Cal services;
- Contracting for Medi-Cal services; and
- Program planning and development.

The May Revision is requesting an increase of $218,000 ($108,000 Reimbursement from schools and $108,000 in federal funds) to fund three positions to do a wide variety of functions related to meeting federal oversight functions that pertain to MAA and usage at the schools and counties.

Subcommittee Staff Recommendation: It is recommended **to adopt the proposal.** No issues have been raised.

Budget Issue: Does the Subcommittee **want to adopt the May Revision?**

14. Cancer Research Program—Senate Changes & Administration's Trailer

Background and Governor's January Budget: Chapters 755 and 756, Statutes of 1997 (AB 1554, Ortiz and SB 273 Burton), created the Cancer Research Act of 1997. From 1998 to 2001, the annual Budget Act provided $25 million (General Fund) for this program.

Due to fiscal constraints, the Budget Act of 2002 and accompanying legislation (1) reduced the appropriation level to $12.5 million, **(2)** allowed for the receipt of private donations to the program, **(3)** capped the indirect costs for the grants at 25 percent, ***and*** **(4)** provided for multiple-year contracting for the grants.

The Governor's Mid-Year proposal further reduced this program by another $6.25 million (50 percent) in the current-year. **His January budget proposes elimination of the funding in its entirety.**

Governor's May Revision (See Hand Out): The May Revision **(1)** continues the elimination of funding, and **(2)** proposes to provide multi-year authority to carry forward any unexpended Cancer Research funds from the current year (2002-03).

Subcommittee Staff Recommendation: It is recommended to **(1)** provide $6.25 million in General Fund support, **(2)** assume $6.25 million from private donations and foundations, **(3)** adopt the Governor's May Revision trailer bill language to provide for carry-forward authority, and **(4)** adopt Budget Bill Language to require the DHS to actively pursue seeking private foundation funds as required by the statute.

The proposed Budget Bill Language is as follows:

Item 4260-001-0001

The Department of Health Services shall actively pursue seeking private foundation funds, as allowed for under the Cancer Research Program Act.

Budget Issue: Does the Subcommittee **want to (1)** provide $6.25 million (General Fund) support, **(2)** assume $6.25 million from private donations and foundations, and **(3)** adopt Budget Bill Language to require the DHS to actively pursue seeking private foundation funds as required by the statute.

15. Improvement for Enrolling Infants into the CHDP Gateway

Prior Subcommittee Hearing: In the April 21st hearing, the Subcommittee heard compelling public testimony that a minor "fix" was needed for the CHDP Gateway to be able to enroll eligible infants. Senator Chesbro, Chair of the Subcommittee, directed Subcommittee staff to work on the issue.

Improvement to the Gateway—Deemed Eligible Infants: The DHS and constituency groups, including providers of services, have been working diligently through regular meetings of a CHDP Advisory Group. **Through this process, constituency interests have identified a few areas in which the CHDP Gateway could be improved. One of these areas of interest pertains to the enrollment of newborns through the Gateway process.**

While the Medi-Cal Program has existing statutory authority (Section 14011.4, of W&I Code) to perform the enrollment of newborns, the statutory authority of the CHDP Gateway is strictly limited to performing eligibility determinations for either the CHDP-Only eligibility or pre-enrollment eligibility funded either through Medi-Cal or the Healthy Families Program.

Based on technical assistance obtained from the DHS, to include newborn enrollment as part of the CHDP Gateway process an increase of $785,000 ($196,000 General Fund) is needed for 2003-04-- the first year expenditure which includes some one-time-only system development costs. ***The DHS states that on-going expenditures would be $128,000 ($32,000 General Fund) annually.*** **As noted by the DHS, the establishment of this process is not expected to significantly change the services Medi-Cal pays for newborns.**

In addition, statutory change would be needed (to Section 14011.4 of W&I code) to perform the newborn enrollment. Suggested language is as follows:

> Proposed New subdivision to Section 14011.4:
>
> "(b) In addition t the implementation of a program of pre-enrollment of children into Medi-Cal or Healthy Families programs as described in subdivision (a), the department may, at its option, use the electronic application described in subdivision (c) to also serve as a means to enroll newborns into the Medi-Cal Program as is authorized under 42 United States Code section 1396a(e)(4)."

Constituency groups note that by making this small modification to the Gateway, barriers to the enrollment of newborns would be low and infants would start to receive more timely health care coverage.

Subcommittee Staff Recommendation: It is recommended to provide an increase of $785,000 ($196,000 General Fund) (of which $164,000 is one-time only General Fund) and to adopt trailer bill language as specified above to proceed with the "fix" for the deemed eligible infants.

Budget Issue: Does the Subcommittee **want to adopt the recommendation?**

16. Tobacco Settlement Fund GF Loan *(See Hand Out)*

Governor's May Revision: The May Revision proposes to modify the amount the Tobacco Settlement Fund provides to the General Fund as contained in existing code Section 104425 of the Health and Safety Code. **Currently the transfer amount is $250 million. The May Revision changes this to $100 million.** Specifically, these are the funds that are not otherwise appropriated.

Budget Issue: Does the Subcommittee want to adopt the proposed change?

17. The LEADER Project *(See Hand Out)*

Governor's May Revision: The May Revision requested Budget Bill Language to reduce the monthly Medi-Cal county administration base allocation to Los Angeles County by 15 percent until sufficient progress is made in implementing system changes in the Statewide Automated Welfare System—Los Angeles Eligibility, Automated Determination, Evaluation and Reporting (LEADER) Consortium system. These changes would automate the eligibility determination process for the Section 1931(b) and continuous eligibility for children's aid categories.

Subcommittee Staff Recommendation: The **DHS, DOF and County of Los Angeles have re-crafted the proposed Budget Bill Language contained in the May Revision and have reached consensus.**

Budget Issue: Does the Subcommittee **want to adopt the revised Budget Bill Language as agreed to by the affected parties and as contained in the Hand Out?**

18. Technical Sweep of Special Deposit Fund for General Fund Backfill

Background and Subcommittee Staff Recommendation: Subcommittee staff has become appraised that $4.7 million in Surplus Money Investment Fund interest is available to transfer to the General Fund as an offset. The $4.7 million is unencumbered and resulted from the original transfer of General Fund moneys to a special account whose purpose has now been fulfilled. This special deposit fund is pursuant to Government Code Section 16370 and is technically referred to as Special Deposit Fund number 0942-14.

Therefore, it is recommended to terminate Special Deposit Fund number 0942-14 and to transfer the full amount—approximately $4.7 million to the General Fund as an offset. This will result in General Fund savings of $4.7 million.

Budget Issue: Does the Subcommittee **want to terminate Special Deposit Fund number 0942-14 and transfer the full amount—about $4.7 million in unencumbered funds—to the General Fund as an offset?**

19. Medi-Cal Program-- Provision of Dental Services for Pregnant Women

Background and Subcommittee Staff Recommendation: The May Revision for the Medi-Cal Program—local assistance—**inadvertently over estimated the amount of funds required to provide Subgingival Curettage and Root Planning (procedure code 452) for pregnant women based on the new rate (i.e., 41 percent less than before) established in SB 26 (X).**

Therefore, the Medi-Cal local assistance budget can be reduced by $2.6 million (General Fund) to reflect the correct rate for this procedure.

Budget Issue: Does the Subcommittee **want to reduce by $2.6 million (General Fund) to reflect the correct rate for this procedure?**

D. BUDGET CONTROL SECTION 17.00--HIPPA

Governor's May Revision: The May Revision proposes to make adjustments to Budget Control Section 17.00 regarding the statewide funding for Health Insurance Portability and Accountability Act (HIPPA) compliance activities. **These proposed changes are noted below:**

> Section 17.00 The Budget Act of 2003 includes ~~$71,927,000~~ **$73,315,000** (~~$18,345,000~~ **$20,019,000 General Fund,** ~~$50,852,000~~ **$50,566,000 federal funds, and $2,730,000 special funds** for the applicant state agencies, departments, boards, commissions or other entities of state government in support of federal Health Insurance Portability and Accountability Act (HIPPA) activities. **These funds are allocated to the following entities:**
>
> - ~~$62,143,000~~ $62,893,000 (~~$12,519,000~~ **$13, 514,000** General Fund, ~~$47,441,000~~ **$47,196,000** federal funds, and **$2,183,000** special funds) for the Department of Health Services;
> - $3,572,000 ($2,971,000 General Fund, $601,000 federal funds) for the CA Health and Human Services Agency;
> - $2,155,000 ($1077,000 General Fund, $1,078,000 federal funds) for the Department of Mental Health;
> - $1,975,000 ($988,000 General Fund, $987,000 federal funds) for the Department of Alcohol and Drug Programs;
> - $901,000 (~~$451,000~~ **$492,000** General Fund, ~~$450,000~~ **$409,000** federal funds) for the Department of Developmental Services;
> - **$638,000** (General Fund) for the Department of Corrections;
> - $500,000 ($205,000 General Fund, $295,000 federal funds) for the Department of Social Services;
> - $225,000 (special funds) for the Department of Personnel Administration;
> - $223,000 (special funds) for the Public Employees' Retirement System;

- $134,000 (General Fund) for the Department of Veteran's Affairs; and
- $99,000 (special funds) for the Office of Statewide Health Planning and Development.

Subcommittee Staff Comment: At the request of the Subcommittee, the LAO reviewed the proposed changed and raised no issues. As such, **it is recommended for the Subcommittee to adopt this proposal.**

Budget Issue: Does the **Subcommittee want to adopt the proposal?**

E. DEPARTMENT OF MENTAL HEALTH *(Vote Only Calendar)*

1. Mental Health Realignment--Technical Adjustment to Prior Subcommittee Action

Subcommittee's Prior Action: In the March 10th hearing, **the Subcommittee *reversed* the Governor's proposed Realignment of mental health programs—the Children's System of Care and the Integrated Services for Homeless Adults Program—for increased General Fund support of $74.9 million. The intent behind this action was to reiterate the importance of these programs and the desire to continue the services provided to individuals with mental illness.**

Subcommittee Staff Recommendation: As such, it is recommended to amend the Subcommittee's prior action to**(1) retain the prior Subcommittee action on March 10th regarding the reversal of realignment** (i.e., use General Fund support for the programs), **(2) reject the Administration's proposed trailer bill** language regarding realignment, ***and*** **(3) include both trailer bill language and Budget Bill Language as follows:**

Proposed Trailer Bill Language:

It is the intent of the Legislature to provide the necessary revenues to support critical mental health and social services programs. Specifically, it is the intent of the Legislature to provide $1.8 billion in new non-General Fund revenues to support program costs associated with realigning $1.7 million in program costs from the State to the counties.

Proposed Budget Bill Language (Item 4440-101-0001)

This Item shall be reduced by up to $74.9 million if legislation that realigns the Children's System of Care Program and the Integrated Services for Homeless Adults Program costs to counties and provides counties revenues to fund the programs is enacted.

Budget Issue: Does the Subcommittee **want to adopt the recommendation to include the two pieces of language, as shown above, along with retaining the prior action to fund these programs using General Fund support?**

2. Healthy Families Program Adjustments—*Supplemental Mental Health Services*

Background: The Healthy Families Program provides health care coverage and dental and vision services to children between the ages of birth to 19 years with family incomes at or below 250 percent of poverty (with income deductions) who are not eligible for no-cost Medi-Cal. Monthly premiums, based on family income and size, must be paid to continue enrollment in the program. **California receives an annual federal allotment of federal Title XXI funds (Social Security Act) for the program for which the state must provide a 34 percent General Fund match, except for supplement mental health services in which County realignment funds are used as the match. With respect to legal immigrant children, the state provides 100% General Fund financing.**

The enabling Healthy Families Program statute linked the insurance plan benefits with a **supplemental program** to refer children who have been diagnosed as being seriously emotionally disturbed (SED). The **supplemental services** provided to Healthy Families children who are SED can be billed by County Mental Health Departments to the state for a federal Title XXI match. **Counties pay the non-federal share from their County Realignment funds** (Mental Health Subaccount) to the extent resources are available.

Under this arrangement, the Healthy Families Program health plans are required to sign Memoranda of Understanding (MOU) with each applicable county. These MOUs outline the procedures for referral. It should be noted that the health plans are compelled, as part of the required Healthy Families benefit package and capitation rate, to provide certain specified mental health treatment benefits prior to referral to the counties.

Governor's May Revision: The **May Revision proposes to increase by $2 million (Reimbursements from federal Title XX funds) to reflect adjustments to the supplemental mental health services provided to children under the HFP based on paid claims data and caseload. This adjustment will provide a total of $21.9 million ($7.4 million County Realignment Funds, $13.7 million federal Title XX funds and $767,000 General Fund) for 2003-04 for these supplemental mental health services.**

Subcommittee Staff Recommendation: Subcommittee staff recommends for **the Subcommittee to adopt the proposal. No issues have been raised.**

3. Infant, Preschool, & Family Member Mental Health Initiative-Prop 10 Commission

Background: In October 2000, the California & Families **Commission awarded the DMH $3.6 million for a two-year period to develop a pilot project for an infant mental health** service delivery system for children from birth to five years of age. The overall goal of this initiative was to expand and enhance the availability and quality for early mental health and relationship-based services for this population. Funding was provided in 2000-01, 2001-02 and 2002-03 due to the late start in allocating funds

The initiative is a collaborative effort involving eight pilot counties (Alameda, Fresno, Humboldt, Los Angeles, Riverside, Sacramento, San Francisco and Stanislaus), DMH and WestED/CEITAN—Center for Prevention and Early Intervention. **Funding is provided to each of the counties to develop their own plans for training, technical assistance and enhanced service delivery based on local resources, existing services and prioritized interests and needs.**

The California Children and Families Commission has notified the DMH to provide an additional $3.5 million to continue the Initiative. These funds would be allocated over a four-year period.

Governor's Proposed May Revision: The May Revision **proposes to provide an increase of $1.250 million (Reimbursements from the California Children and Families Commission) to reflect the additional funding provided by the Commission.** The remaining amounts will be utilized in the subsequent fiscal years ($1 million for 2004-05, and $625,000 in each of the remaining two years).

Subcommittee Staff Recommendation: It is **recommended to adopt the May Revision.** No issues have been raised .

4. Adjustments for San Mateo Field Test Model—Technical for Accrual to Cash

Background: The San Mateo County Mental Health Department has been operating as the mental health plan under a federal Waiver agreement and state statute as a "field test" since 1995. The field test is intended to test managed care concepts which may be used as the state progresses toward consolidation of specialty mental health services and eventually, a capitated or other full-risk model. As the model has matured and evolved, additional components have been added and adjusted.

As part of the contract negotiation with the DMH, trend factors for pharmacy and laboratory costs have been updated to more accurately reflect actual cost-based data. As such, the laboratory costs and pharmacy costs were adjusted in the current year.

Governor's May Revision: The May Revision **proposes a decrease of $2.4 million (Reimbursements from the DHS, of which 50 percent is state General Fund) to reflect technical adjustments to San Mateo's pharmacy and laboratory services as a result of the change in the Medi-Cal Program going from accrual to cash budgeting.**

Subcommittee Staff Recommendation: It is **recommended to adopt the May Revision.** No issues have been raised.

5. Delay Activation of Salinas Valley Psychiatric Program

Governor's May Revision: The May Revision proposes to decrease by $1 million in Reimbursements to reflect a delay in the activation of the Salinas Valley Psychiatric Program.

Subcommittee Staff Recommendation: It is recommended to approve the May Revision. No issues have been raised.

Budget Issue: Does the Subcommittee **want to adopt the May Revision?**

6. Delay Activation of Coalinga State Hospital

Governor's May Revision: The May Revision proposes to decrease by $5 million ($1.250 million General Fund) to reflect a delay in the implementation of federal regulations requiring External Quality Reviews of County Mental Health Plans.

Subcommittee Staff Recommendation: It is recommended to approve the May Revision. No issues have been raised.

Budget Issue: Does the Subcommittee **want to adopt the May Revision?**

7. Reversion Item

Governor's May Revision: The May Revision proposes to revert $478,000 (General Fund) in previously appropriated, but unexpended funds, contained in the Budget Act of 2001.

Subcommittee Staff Recommendation: It is recommended **to adopt the May Revision**. No issues have been raised. **This action would conform with the Assembly.**

Budget Issue: Does the Subcommittee **want to adopt the May Revision?**

5. Early Periodic Screening Diagnostic & Treatment –Proposed Change in Fiscal Methodology

Background—Overall: **Most children receive Medi-Cal services through the EPSDT Program**. Specifically, EPSDT is a federally mandated program that requires states to provide Medicaid (Medi-Cal) **recipients under age 21 *any* health or mental health service that is medically necessary** to correct or ameliorate a defect, physical or mental illness, or a condition identified by an assessment, **including services not otherwise included in a state's Medicaid (Medi-Cal) Plan.**

Though the DHS is the "single state agency" responsible for the Medi-Cal Program**, mental health services including those provided under the EPSDT, have been delegated to be the responsibility of the Department of Mental Health (DMH)**. Further, **counties are responsible for providing, arranging and managing Medi-Cal mental health services under the supervision of the DMH and DHS. However, eligibility and the scope of services to which eligible children are entitled, are *not* established at the local level.**

Types of Services: The state uses the term **"EPSDT supplemental services**" to refer to EPSDT services which are required by federal law **but are not otherwise covered under the state Medi-Cal Plan for adults**. **Examples of services include family therapy, crisis intervention, medication monitoring, and behavioral management modeling.**

Prior Subcommittee Hearing: In the March 10th hearing, the Subcommittee discussed the proposed changes in the methodology for the EPSDT at length.

Governor's May Revision: The May Revision reflects a decrease of almost $11.6 million in Reimbursements to reflect a technical correction to expenditures included in the Governor's January budget based on statistical validation of this estimating methodology. There is no reduction in services as a result of this change.

Budget Issue: Does the Subcommittee **want to adopt the May Revision?**

6. Sexually Violent Predator Evaluations

Governor's May Revision: The May Revision proposes to increase this item by $2.051 million (General Fund) to reflect an increase in the number of SVP evaluations to be performed by private contractors, as well as additional costs for evaluator testimony.

Subcommittee Staff Recommendation: It is recommended to adopt the May Revision.

Budget Issue: Does the Subcommittee **want to adopt the May Revision?**

II. ITEMS FOR DISCUSSION

A. Managed Risk Medical Insurance Board (*Discussion Items*)

The Managed Risk Medical Insurance Board (MRMIB) administers programs, which provide health coverage through private health plans to certain groups without health insurance. **The MRMIB administers the (1) Healthy Families Program, (2) Major Risk Medical Insurance Program, and (3) Access for Infants and Mothers (AIM).**

1. Healthy Families Program Estimate—*Children's Program Adjustments*

Background—Overall on the HFP: The Healthy Families Program provides health, dental and vision coverage through managed care arrangements to uninsured children in families with incomes up to 250 percent of the federal poverty level. Families pay a monthly premium and copayments as applicable. The benefit package is modeled after that offered to state employees. Eligibility is conducted on an annual basis.

Parent Expansion with Waiver: **The Governor is proposing to continue the delay of implementation of the HFP Parents expansion.** However, the Legislature does not need to take action regarding this proposal since the HFP Parent expansion can only occur if an appropriation is made for that purpose *(Reference Section 12693.755 of Insurance Code).* As such, the existing statute regarding the HFP Parent expansion can remain as presently crafted.

Governor's Proposed May Revision: **A total of $794.5 million ($120.9 million General Fund, $173.4 million Tobacco Settlement Fund, $492.5 million Federal Title XXI Funds and $7.7 million Reimbursements) is for local assistance. This level of funding assumes a total enrollment of 726,625 children as of June 30, 2004.**

The May Revision reflects *a net reduction of $15.2 million* (decrease of $182.6 million General Fund, $2.7 million in federal Title XXI funds and $3.3 million in Reimbursements, and an **increase of $173.4 million Tobacco Settlement Funds**). **The key factors included in this adjustment are as follows:**

- Assumes a **reduction in the estimated caseload enrollment of 41,607 children**, as compared to the Governor's January budget. The MRMIB states that this reduced enrollment is anticipated due to the elimination of outreach funding.
- A new Administrative Vendor contract was awarded to MAXIMUS and takes effect as of January 1, 2004. Under the terms of this new contract, the per member per month payment will be $4.10.
- $91.46 *(average cost)* for health, dental and vision plan payments per child per month (eligible children aged 1 to 19 years). This reflects a 2.8 percent increase over the January budget amounts. **The actual monthly rate paid is based on MRMIB negotiating with the participating plans through a model contract process.**

- $214.99 (average cost) for health, dental and vision plan payments per infant per month (o to 1 years). This is the same amount as proposed in January. **The actual monthly rate paid is based on MRMIB negotiating with the participating plans through a model contract process.**

Subcommittee Request and Questions: The Subcommittee has requested the MRMIB to respond to the following questions:

- **1.** Please **provide a brief summary of the *key adjustments* to the HFP May Revision** enrollment of children.
- **2.** Please **briefly explain the transition of the Administrative Vendor to MAXIMUS**.

Budget Issue: Does the Subcommittee **want to adopt the May Revision for the HFP enrollment of children?**

2. Access for Infants and Mothers (AIM) Program

Background—Existing Program: The Access for Infants and Mothers (AIM) Program **provides health insurance coverage to uninsured women during pregnancy and up to 60 days postpartum, and covers their infants up to two years of age.**

Eligibility is limited to families with incomes from 200 to 300 percent of the poverty level, including the application of Medi-Cal income deductions. (Generally, women below 200 percent of poverty are eligible for Medi-Cal.) **Subscribers must be no more than 30 weeks pregnant and pay a subscriber contribution equal to 2 percent of the family's annual income (average of $790) plus $100 for the infant's second year of coverage, or only $50 if the infant's vaccinations are current.** AIM is not an entitlement program. The level of available funding determines the enrollment capacity.

Currently, AIM offers coverage through **9 contracted health plans.**

Governor's Proposed Budget—Shift Eligible Infants to the Healthy Families Program: In order to address funding and caseload issues in AIM, the Administration proposed **to consolidate AIM and enroll *eligible* infants into the Healthy Families Program (HFP) at birth while continuing to provide women with prenatal and postpartum care through AIM. This proposal applies to infants born to women who enroll in AIM on or after July 1, 2004.**

The MRMIB states that by merging AIM in this manner, the state should be able to obtain lower health plan rates for infants via the Healthy Families Program (larger risk pool), as well as achieve other economies of scale through consolidating certain program administration. **Specifically, infants in families *between 200 and 250 percent of poverty* would be funded through the Healthy Families Program using General Fund and federal Title XXI funds (35 percent General Fund to draw a 65 percent federal match).**

AIM infants in families *between 250 and 300 percent of poverty* (above the Healthy Families Program income threshold) would be funded with 100 percent state funds (Proposition 99 Funds).

Although there is no budget year fiscal effect due to the July 1, 2004 implementation date, the Administration assumes net annual savings of $10 million at full implementation. The fiscal affect of this is based on a comparison of the cost of pregnant women and their infants under the current AIM Program versus the infants' cost under the HFP.

Prior Subcommittee Hearing: In the March 3rd hearing, **the Subcommittee discussed both the policy and fiscal aspects of this merger and concurred that it was a reasonable approach.**

Governor's May Revision: The average monthly enrollment is expected to reach 13,119 women and infants, compared to 12,314 as originally estimated in **the January Budget which represents an increase of 6.5 percent Budget year expenditures are reflecting an increase of $1.5 million ($647,000 General Fund) due to greater than anticipated enrollment of infants in the program and an increase in the average monthly capitation rates.**

Subcommittee Request and Questions: The Subcommittee **has requested the MRMIB to respond to the following question:**

- Please **briefly** discuss the **key changes** from the January budget release. **Is the MRMIB still anticipating the merger to occur as of July 1, 2004?**

B. DEPARTMENT OF HEALTH SERVICES—Public Health *(Discussion Items)*

OVERALL SUMMARY CHART OF THE DHS *(Informational)*

Dollars in Thousands	Governor's Proposed Budget (January)	Spring Finance Letters	May Revision Proposals	Governor's Final Proposed 2003-04
State Positions	**5,992.3**	**17.5**	**552.7**	**6,562.5**
State Support $				
General Fund	$224.2 million	$425,000	$18 million	$262.6 million
Federal Fund	372.6 million	-332,000	83.5 million	455.8 million
Other Funds	220.6 million	1.7 million	-2 million	220.3 million
Total Support	**$837.3 million**	**$1.8 million**	**$99.6 million**	**$938.7 million**
Local Assistance $				
General Fund	$7.311 billion	$6.9 million	$2.856 billion	$10.174 billion
Federal Fund	17.291 billion	0	-185.5 million	17.105 billion
Other Funds	2.222 billion	-3.1 million	60.5 million	2.280 billion
Total Local Asst	**26.824 billion**	**$3.8 million**	**$2.731 billion**	**$29.558 billion**
TOTAL ALL	**$27.661 billion**	**$5.6 million**	**$2.831 billion**	**$30.497 billion**

PUBLIC HEALTH ISSUES—(*Discussion Items)*

1. AIDS Drug Assistance Program—*Several Issues (Copay, Rebates and Other)*

Background--ADAP: The AIDS Drug Assistance Program (ADAP), established in 1987, is a subsidy program for low and moderate income persons (individual income cannot exceed $50,000) with HIV/AIDS who have **no health insurance coverage for prescription drugs** and are ***not*** **eligible** for the Medi-Cal Program. **There are about 26,000 clients currently enrolled in ADAP.**

Under the program eligible individuals receive drug therapies through participating local pharmacies under subcontract with the statewide contractor. The state provides reimbursement for drug therapies listed on the ADAP formulary (**about 146 drugs currently**). **The formulary includes anti-retrovirals, hypolipidemics, anti-depressants, vaccines, analgesics, and oral generic antibiotics.**

ADAP is cost-beneficial to the state. Without ADAP assistance to obtain HIV/AIDS drugs, **infected individuals would be forced to (1)** postpone treatment until disabled and Medi-Cal eligible or **(2)** spend down their assets to qualify for Medi-Cal. About 50 percent of Medi-Cal costs are borne by the state, as compared to only 30 percent of ADAP costs. Since the AIDS virus can quickly mutate in response to a single drug, medical protocol now calls for Highly

Active Antiretroviral Treatment (HAART) which minimally includes three different anti-viral drugs. As such, expenditures in ADAP have increased.

Governor's January Budget: **The January budget proposed total ADAP funding** of **$186.4 million ($60.5 million General Fund, $92.6 million federal Ryan White CARE Act Title II funds, $33.2 million in mandatory drug rebates from the manufacturers) for the budget year.** The January budget assumed a net increase of $2.3 million over the 2002-03 current-year for ADAP.

The January budget made the following key assumptions:

- A reduction of $7.2 million (General Fund) to reflect implementation of a new Copay requirement of $30, $45 and $50 per prescription for ADAP participants;
- Increase of **$1.240 million in drug manufacturer rebates which would be on-going; (This assumed that the DHS will be able to obtain an *average* rebate about 13 percent.)**
- Increase of $8.3 million (General Fund) to make adjustments to the ADAP base; **and**
- Increase of **$8 million *(one-time only)*** in drug manufacturer rebates, which have recently been collected, to offset General Fund support.

Governor's May Revision—Changes Copay and Makes Other Changes: The **May Revisions proposes total ADAP expenditures of $195 million** ($58.1 million General Fund, $95.4 federal funds, $41.4 million drug rebate funds, and $ 1.4 million in revenues for the revised Copay). **The May Revision reflects a net increase of $2.8 million** (increase of $2.8 million federal funds and $8.2 million in additional drug rebates, and a decrease of $8.2 million in General Fund support) **over the proposed January budget.**

The May Revision makes the following key assumptions:

- A net increase of **$2.8 million federal funds**;
- Increase of **$8.2 million in drug rebates which is being used to *offset* General Fund** support (this reflects an increase of $5.8 million used to offset the Copay proposal change from January); ***and***
- Imposition of a **new Copay proposal** which is to obtain about **$1.4 million in revenues** which will be used to offset General Fund support (this amount reflects the revised proposal of $5, $10 and $15 for Copays);

Under the Administration's revised Copay proposal, the amount paid by ADAP to pharmacies would be reduced by the copay amount, thus decreasing the overall costs to ADAP. The May Revision proposes to reduce the Copay proposal from $30, $45 and $50 dollars per prescription to $5, $10 and $15 dollars respectively based on a sliding income scale tied to federal poverty levels.

Prior Subcommittee Action: In the April 21st hearing, **considerable testimony was taken which expressed severe concerns regarding any Copay proposal.**

Subcommittee Staff Comment and Recommendation : **First,** negotiations between state AIDS drug programs and pharmaceutical manufacturers has been occurring. To-date, at least three companies have reached agreements with the states to provide additional rebates of $25 million. In addition, there are three other companies which represent a significant market share of the industry that have yet to reach agreement. **Based on historical calculations, California should receive about 13 percent, or about $3.3 million, of this new rebate amount.**

Second, based on more recent rebate collection information that has occurred since the May Revision was produced**, there is an additional $3.8 million available from more drug rebates.**

Third, after discussions with some interest groups regarding the allocation of scarce resources in these difficult fiscal times, it is recommended **to provide the DHS authority to transfer up to $7 million from funds presently appropriated to conduct viral load testing and HIV drug resistance testing, and related activities.**

Fourth, based on historical calculations of drug rebate funds, **the state receives about 13 percent in additional rebates based on new drug expenditures.** As such, **the additional $14.1 million in additional funds identified above, will produce another $1.833 million in rebate funds, for a total of about $16 million in additional funding resources.**

In order to capture these additional resources, the following technical actions are recommended:

- **Adopt Budget Bill Language for transfer of funds** as follows:

  Item 4260-111-0001
  Of the amount appropriated in this Item for the HIV Therapeutic Monitoring Program, up to $7,000,000 may be transferred by the department to the AIDS Drug Assistance Program (ADAP) for expenditure.

- **Adopt trailer bill language to make the HIV Therapeutic Monitoring Program contingent upon appropriation** in the Budget Act or other statute and clarify the purpose of the program, including priority for funding Early Intervention Program sites. (This is really more of a technical issue so as to make it clear what the HIV viral load testing program is and to enable the DHS to transfer funds from it to the ADAP.) ***(Hand Out).***
- **In lieu of the DHS language** regarding waiting lists, **adopt trailer bill language crafted with constituency groups to allow for waiting lists and other administrative remedies** ***(See Hand Out). and***
- **Reject the Administration's Copay proposal and trailer bill language and backfill with General Fund ($1.448 million)**

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please **briefly explain the *key* aspects** of the Administration's proposal.
- **2.** How have the **negotiations between state AIDS drug programs and pharmaceutical manufacturers at the national level been going?**

Budget Issue: Does the **Subcommittee want to provide $16 million in additional resources to the AIDS Drug Assistance Program (ADAP) by (1)** adopting Budget Bill Language to allow for the transfer of up to $7 million from the HIV Therapeutic Monitoring Program, **(2)** recognizing increased rebates in the amount of $9 million, as noted above, **(3)** adopting the alternative waiting list language as contained in the Hand Out, and **(5)** rejecting the Copayment proposal and backfilling with $1.448 million (General Fund)?

2. Continuation of Bioterriorism Efforts—Increased Federal Funds

Background—Overall Summary: The Emergency Supplemental Appropriations for Recovery & Response to Terrorist Attacks on the US Act (Public Law 107-117 of 2002), and subsequent federal legislation, among many other things, **provided states with additional federal funds to support and address both local and state concerns regarding the threat of bioterrorism.**

Under the *initial* supplemental grant award in 2002, there were two funding streams made available to California: (1) $60.8 million from the federal Centers for Disease Control (CDC) in support of state and local public health measures to strengthen the state against bioterrorism via a "cooperative agreement" to the DHS; and **(2)** about $10 million from the federal HRSA for the development and implementation of regional plans to improve the capacity of hospitals, their emergency departments, outpatient centers, emergency medical systems and related matters.

California's *new* 12-month cycle (August 31, 2003 through August 30, 2004) **is $94.4 million (federal funds), of which $55.6 million is from the federal CDC and $38.8 million is from HRSA. However for state budgeting purposes, only ten months of the federal fiscal year is captured. Therefore, this allocation will cross over two state fiscal years.**

As such, the DHS is requesting budget authority of $82.8 million for 2003-04 as shown in the table below.

DHS May Revision Revenue & Expenditures By State Fiscal Year	Federal CDC	Federal HRSA	Total (Federal Funds)
2003-04 (***Prior grant*** 2 months available)	$7.283 million	488,000	$7.771 million
2003-04 (***New grant*** 10 months available)	$42.767 million	$32.311 million	$75.078 million
Total Revenues	**$50.050 million**	**$32.799 million**	**$82.849 million**
State Operations--identified	$5.962 million	0	$5.962 million
State Operations--***unidentified***	**$19.063 million**	**$32.799 million**	**$51.862 million**
***Subtotal*—State Operations**	***($25.025 million)***	***($32.799 million)***	***($57.824 million)***
Local Assistance	$25.025 million	0	$25.025 million
Total Expenditures	**$25.025 million**	**$32.799 million****	**$57.824 million**

****It should be noted that **of the $32.8 million in federal HRSA funds, 80 percent must go to hospitals, clinics and other health care provides per the federal HRSA guidance.**

According to the DHS, the **recently released federal guidance documents include the addition of numerous critical benchmarks and requirements to both grants. As such, the DHS notes that they are *just beginning* the process of re-application for next year's federal monies in cooperation with state and local partners.**

It should be noted that the federal government had been requiring state's to use seven key areas of focus, including: Preparedness Planning and Readiness Assessment, Surveillance and Epidemiology Capacity, Biologic Laboratory Capacity and Biologic Agents, Laboratory Capacity –

Chemical Agents, Health Alert Network, Risk Communication and Health Information, and Education and Training.

Governor's May Revision (See Above Chart for Fiscal Detail): The May Revision **requests an increase of $82.8 million (federal funds from the CDC and HRSA) to support state and local activities to continue bioterrorism preparedness and response activities. Of the total amount, (1) $57.8 million is for state support activities, *and* (2) $25 million is for local assistance *(See above chart for fiscal detail).***

In addition, the **DHS is requesting two pieces of Budget Bill Language** that provides for transfer authority between state support and local assistance (both ways), as discussed below.

The DHS is proposing to expend the requested $57.8 million (federal funds) on *state support* as follows:

- **$3.6 million is for the Infant Botulism proposal** ***(discussed as separate item in the agenda, below.)***
- About **$7.5 million is to be used to support 76 positions**, including operating expenses, data communication and facility operations. **The DHS is proposing to allocate these positions based on the seven federal areas of focus as follows:**
    - **15 positions** for Preparedness Planning and Readiness Assessment
    - **26 positions** for Surveillance and Epidemiology Capacity
    - **17 positions** for Biologic Laboratory Capacity and Biologic Agents
    - **5 positions** for Laboratory Capacity –Chemical Agents
    - **4 positions** for Health Alert Network
    - **3 positions** for Risk Communication and Health Information
    - **6 positions** for Education and Training
- **About $50.5 million is to be spent by the DHS on other items of expense; however, no detail is available for this item.**

The DHS is **requesting flexibility** in the appropriation **by requesting the following Budget Bill Language transfer authority between items (state support and local assistance):**

- **Item 4260-001-0890 (DHS state support, federal funds appropriation)**
  The Department of Finance may authorize the transfer of amounts **between this Item and Item 4260-111-0890** to reflect modifications in the use of federal bioterrorism grants. The funds shall not be approved sooner than 30 days after notification in writing of the necessity therefor to the Chairperson of the Committee of each house of the Legislature that considers appropriations and the Chairperson of the Joint Legislative Budget Committee, or his or her designee, may in each instance determine.

- **Item 4260-111-0890 (DHS local assistance, federal funds appropriation)**
  The Department of Finance may authorize the transfer of amounts **between this Item and Item 4260-001-0890** to reflect modifications in the use of federal bioterrorism grants. The funds shall not be approved sooner than 30 days after notification in writing of the necessity therefor to the Chairperson of the Committee of each house of the Legislature that considers appropriations and the

Chairperson of the Joint Legislative Budget Committee, or his or her designee, may in each instance determine.

Subcommittee Staff Comment and Options Available: As noted above, **the DHS is just beginning their process** and the federal government was late in releasing the guidelines this year. **Local Health Jurisdictions, Public Health Officers, as well as others, have had very little opportunity to discuss key aspects of the federal guidelines and funding mechanisms.**

As such, the **May Revision has inadvertently created a situation whereby the DHS is requesting the Legislature to appropriate a significant level of funding without providing appropriate and necessary detail. Local public health infrastruture and funding is of critical importance to the state, yet the May Revision identifies only $25 million of the $82.8 million for this purpose at this time. Though the DHS intends to have a cooperative effort with interested parties and will likely be commencing** with "focus groups" on key topics, it is unclear as to how the ultimate plan will take shape.

Therefore, it is recommended to **(1)** appropriate the $25 million (federal funds) for local assistance, **(2)** reject the Budget Bill Language that would enable the state to transfer funds from the local appropriation (Item 4260-111-0001) to state support (Item 4260-0001-0001), and **(3)** reduce the $57.8 million (federal funds) for state support by half (i.e., $28.9 million) in order to send the proposal to Budget Conference Committee for further discussion. **In addition, this will provide the DHS with more time to work with local constituency groups to craft a workable solution.**

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please briefly describe what allocation process was used last year and how this one differs.
- **2. What are the time frames for providing the plan to the federal government?**
- **3.** Please describe how the **"focus groups"** are to operate. **Anything else regarding how the state is going to proceed with determining funding priorities?**
- **4.** Please **briefly describe the need to continue the 76 positions.**
- **5.** How will the **$25 million in local assistance funds be allocated?**

Budget Issue: Does the Subcommittee want **to modify the May Revision as suggested by Subcommittee staff?**

3. Infant Botulism—Continue the Program, But Use Federal Funds

Background: Botulism is the paralyzing disease caused by botulinum toxin, the most poisonous substance known. It is produced under special conditions by spore-forming bacteria that are commonly found worldwide in soils and dust. Infant botulism occurs when the botulism bacteria temporarily colonize and produce toxin in the baby's intestine and is the most common form of human botulism in the U.S.

Botulism Immune Globulin (BIG) is the DHS-sponsored orphan drug that treats infant botulism by neutralizing botulinum toxin, thus preventing further paralysis. BIG is the only antidote available for infant botulism. It is made by harvesting and bottling special antibodies from the blood plasma of volunteer donors. Most of these plasma donors are current or former employees of the DHS who have been immunized with botulinum toxoid for occupational safety.

The license application for BIG is in its final stages (to be issued by the end of 2003). The federal FDA has made the completion and execution of the BIG (Lot 3) production, distribution and management contracts a condition of licensure for BIG. **Achieving licensure for BIG is fundamental because it will allow the state to recoup all its costs ($2.8 million in loans from the General Fund) for developing BIG and running the program.**

The original program was adopted by the Legislature and funded in 1996 (a total of 9 positions were allocated over time for this purpose).

Governor's May Revision: The May Revision **is requesting an increase of $3.558 million (federal grant funds from the CDC for bioterrorism) to fund four positions and to contract ($3 million total) for certain specified functions.**

The four positions include: two Public Health Medical Officers III, one Health Program Specialist, and one Public Health Microbiologist II. A total of $25,000 is also needed for certain laboratory supplies.

The DHS states that a key role of BIG production is obtaining the human plasma that contains the antibodies that neutralize botulinum toxin. Once the plasma is obtained, all subsequent operations and FDA compliance expertise are obtained through qualified and FDA-approved contractors. These contractors have been specified in the license application for BIG. **The $3 million in contracts would address the following key items:**

- Plasma collection, testing and shipment
- Conducting FDA-approved validated assay, pre-licensure inspection, records review, reporting, potency and stability reviews
- Vialing of fractionated plasma
- BIG production validations, other regulatory affairs
- Distribution

Subcommittee Staff Recommendation: It is recommended **to adopt the May Revision along with the following Legislative Intent Language in order to make clear that the federal**

bioterrorism funds to be used for this purpose need to recognized as being a portion of the state's share of the available federal funds, not Local Health Jurisdictions share of the funds.

Item 4260-001-890 (DHS, state support, federal funds)

Provision x. It is the intent of the Legislature that all federal funds utilized to continue the Infant Botulism Program be count solely towards the state's share of the available federal funds received from the federal government to mitigate bioterrorism.

Subcommittee Request and Questions: The Subcommittee **is requesting the DHS to respond to the following questions:**

- **1.** Please **briefly summarize** the DHS request.
- **2.** When can the $2.8 million in General Fund loans be paid back?
- **3.** When will **this program be self-supporting** so the federal funds could be used for other/additional bioterrorism purposes?

Budget Issue: Does the Subcommittee want **to adopt the May Revision along with the proposed Legislative Intent Language as shown above?**

4. Proposition 99 Funded Programs for the DHS *(See Hand Outs)*

Overall Background—General : Proposition 99, the Tobacco Tax and Health Protection Act of 1988, established a surtax of 25 cents per package on cigarettes and other tobacco products, and provided a major new funding source for health education, indigent health care services, and resources programs.

Under the provisions of Proposition 99, **revenues are allocated across six accounts based on specified percentages. These are**: **(1)** Health Education Account—20 percent, **(2)** Hospital Services Account—35 percent, **(3)** Physician Services Account—10 percent, **(4)** Research Account—5 percent, **(5)** Unallocated Account—25 percent, and **(6)** Public Resources Account—5 percent (discussed in Subcommittee No. 2).

Governor's May Revision—Revenues: Proposition 99 **revenues are projected to increase slightly from $307.7 million in January to $308.2 million in May. Along with other technical adjustments, there is a total of $349.8 million available for expenditure (for all accounts, including the Public Resources Account).**

It should also be noted that, as required by Proposition 10, the State Board of Equalization transferred $10.4 million as necessary to offset the loss in revenue to the Health Education and Research accounts.

Governor's May Revision—Expenditures (See Hand Out): The May Revision makes a series of adjustments. **First,** the Governor rescinded his Realignment proposal contained in his January budget. (In a prior hearing, the Subcommittee rejected his Realignment proposal.) **Second**, **there are a series of key programmatic adjustments; these are discussed below.**

Health Education Account Programs:

- Provides **$19 million for the Media Campaign** (increase of $2.4 million)
- Provides **$18.8 million for Competitive Grants** (increase of $1.5 million)
- Provides **$19.5 million for Local Lead Agencies** (increase of $4.5 million)

Health Care Programs (Hospital Services, Physicians', & Unallocated Accts):

- Provides $392,000 for Childrens Hospitals (no change)
- Provides $6.8 million for EAPC Clinics (reversal of Realignment proposal)
- Provides $48.3 million for the **CA Healthcare for Indigents Program** (reversal of Realignment proposal). (It should be noted that this program was funded at $77 million in 2002-03.) This program took the single largest reduction, primarily due to lower Proposition 99 revenues.
- Provides $24.8 million in funds to continue funding for Emergency Medical Physicians (uncompensated hospital emergency services). This proposal includes trailer bill language to provide for this adjustment. This is the same language, with appropriate technical adjustments that has been approved for several years.)
- Provides $4.6 million for Rural Health Services (reversal of Realignment proposal)
- Provides $15.6 million for the Breast Cancer Early Detection Program (same as January)
- Provides $7.4 million for DHS administration of various programs

Governor's May Revision—Trailer Bill Language: The May Revision is proposing two changes to existing statute that pertain to **(1)** the Tobacco Competitive Grants, and **(2)** multi-year funding of the Tobacco Control Program. The DHS will briefly discuss each of these.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following question:

- **1. Please briefly describe the proposed *key* reductions** for your programs as referenced above.
- **2. Please briefly describe** the proposed **trailer bill legislation.**

Budget Issue: Does the Subcommittee **want to adopt the May Revision?**

5. Genetically Handicapped Persons Program—May Revision Local Assistance *(See Hand Out)*

Background—Services Provided and Reimbursement: The GHPP **provides diagnostic evaluations, treatment services, and medical case management services for adults with certain genetic diseases**, including cystic fibrosis, hemophilia, sickle cell disease, Huntington's disease, and certain neurological metabolic diseases. **The services covered by the GHPP include all the medically necessary medical and dental services needed by the client, not just the services related to the GHPP-eligible condition. (GHPP differs from the California Children's Services (CCS) Program in that CCS covers only services related to the CCS eligible condition.)**

GHPP is suppose to be the "payer of last resort" (as a 100 percent General Fund program) meaning that third-party health insurance and Medi-Cal coverage are to be used first. GHPP authorized services are **reimbursed according to the following guidelines** established by the DHS:

Background—Hemophilia and Its Treatment: Generally, patients with hemophilia refers to a group of bleeding disorders, most commonly "factor 8" and "factor 9" deficiencies but also include von Willebrands Disease and other "factors". Patients with these disorders are classified based on their level of procoagulant that is deficient. Disease management through comprehensive hemophilia treatment centers is often recommended.

Individuals with these disorders require treatment with factor concentrates for bleeding episodes. These factor concentrates are medications that are either made through purification of plasma proteins or through a process of genetic engineering. These products are clinically complex and cannot be considered interchangeable. Prescriptions are usually written as brand name prescriptions after discussion of the particular product between patient and caregiver.

DHS Notes Substantial Cost Increases: **Expenditures for the GHPP have been rapidly increasing over several years.** In fact, the program **increased well over 320 percent from 1996 to 2001** ($12 million General Fund to $38.8 million General Fund).

According to the DHS, a primary reason for the rapidly rising costs are increases in blood factor expenditures for the hemophilia population.

Prior Subcommittee Action: In the **April 21st hearing, the Subcommittee took the following actions in response to the Governor's January budget:**

- **Approved all three of the requested state positions** to conduct a variety of functions related to blood factor product monitoring and rebate design, and to revise certain GHPP regulations.
- **Deleted $100,000** ($61,000 General Fund) for consultant outreach services.
- **Directed DHS and interested parties to continue working on the draft trailer bill** language regarding blood factor rebates and related items.
- **Deleted trailer bill language** regarding broad authority to contract out ***any*** **service** (i.e., Administration's proposed language in Section 125190 (a)—from April 21 Hand Out package.)

In addition, the Subcommittee (1) directed the DHS and interested parties to continue work on the blood rebate language, and **(2)** kept **open** the Governor's proposed 15 percent rate reduction.

Governor's May Revision: The May Revision proposes **total expenditures of $42.4 million (General Fund) for an increase of $6.2 million (General Fund)** over the Governor's proposed January budget. **Of the increase expenditures, $2.5 million is attributed to Novo 7 blood factor increases and $3.6 million is due to increases in utilization and caseload adjustments.**

The caseload is estimated to be 1,781 individuals (873 GHPP-only and 908 GHPP/Medi-Cal eligible). This reflects an increase of 3 percent for GHPP-only and a decrease of 5.8 percent for GHPP/Medi-Cal eligible.

Key May Revision proposals are as follows:

- **Increase of $2.5 million (General Fund) for Novo 7 blood factor product** which is a new product for hemophilia patients with resistance to standard factor products.
- ***Revised*** Trailer Bill Language ***(See Hand Out)*** **which pertains to (1)** implementing utilization controls on blood factor products, **(2)** assuring that other health coverage is used before GHPP General Fund expenditures occur, and **(3)** implementing a more efficient system for assessment and collection of client fees. It is assumed that $1 million (General Fund) is saved from these actions in the budget year.
- **A 15 percent provider rate reduction, effective October 1, 2003 (was July 1, 2003) for savings of $3.9 million (General Fund). The DHS states that 85 percent of the GHPP treatment base would be subject to the rate reduction. The Administration proposes to continue this rate reduction to June 30, 2006.** (As noted previously, this proposed rate reduction exempts hospital inpatient and hospital outpatient services, as well as supplemental reimbursements, local assistance interagency agreements, services where the non-federal share is provided by means of a certified public expenditure or contract services designated by the Director of Health Services. In addition, FQHC and Rural Health Centers are also exempted.)
- **Savings of $7.5 million (General Fund) from increased drug rebates** (as provided in the Omnibus Health trailer bill for the Budget Act of 2002).

Subcommittee Request and Questions: The Subcommittee **has requested the DHS to respond to the following questions:**

- **1.** Please **briefly summarize** the **key elements** of the May Revision **local assistance proposal.**
- **2. How would the Administration's proposed change to the payment methodology for blood factor under the Medi-Cal Program (addressed later in this agenda under Medi-Cal) affect the GHPP?**

Budget Issue: In **addition to the actions already taken by the Subcommittee in its April 21st** hearing, **does the Subcommittee want to (1)** adopt the Administration's revised language regarding blood factor utilization and related cost containment, ***and*** **(2)** modify the **proposed 15 percent rate reduction?**

If the Subcommittee rejects the proposed 15% rate reduction, a General Fund backfill of $3.9 million is required.

6. California Children's Services Program—*Governor's May Revision (See Hand Out)*

Background—CCS: The California Children's Services (CCS) Program provides medical diagnosis, case management, treatment and therapy to financially eligible children **with specific medical conditions**, **including birth defects, chronic illness, genetic diseases and injuries due to accidents or violence**. **The CCS services must be deemed to be *"medically necessary"* in order for them to be provided.**

CCS depends on a network of specialty physicians, therapists and hospitals to provide medical care to financially eligible, enrolled children.

It is the oldest managed health care program in the state and the only one focused specifically on children with special health care needs. **By law, CCS services are provided as a separate and distinct medical treatment (i.e., carved-out service). Children enrolled in the Medi-Cal and Healthy Families programs are deemed to automatically meet income eligibility requirements for CCS.**

CCS is jointly operated by the counties and the state. As such, County Realignment funds, state General Fund support, and federal funds (when applicable) are used to support the program.

Prior Subcommittee Action: In the **April 21st hearing, the Subcommittee took the following actions in response to the Governor's January budget:**

- **Approved three of the requested five state positions** to complete work regarding contracting programs for drugs, medical supplies and durable medical equipment for the program.
- **Redirected a position within CCS to analyze product utilization and related functions**.
- **Deleted trailer bill language** regarding broad authority to contract out ***any*** **service** (i.e., Administration's proposed language in Section 125190 (a)—from April 21 Hand Out package.)
- **Directed DHS and interested parties to continue working on the draft trailer bill** language regarding blood factor rebates and related items.

In addition, the Subcommittee (1) directed the DHS and interested parties to continue work on the blood rebate language (same as contained under the GHPP issue above), and **(2)** kept open the Governor's proposed 15 percent rate reduction.

Governor's May Revision (See Hand Out): **The May Revision proposes total expenditures of $198.7 million** ($81.5 million General Fund, $71.3 million County Realignment Funds, $35.7 million federal Title XXI funds, $4.7 million federal Title V funds, $5.5 million contract rebate funds, and $250,000 enrollment fees). **This reflects an increase of $3 million General Fund.**

Key May Revision proposals are as follows:

- ***Revised*** Trailer Bill Language ***(See Hand Out)***
- **15 percent provider rate reduction, effective October 1, 2003 (was July 1, 2003) for savings of $4.2 million ($2.1 million General Fund). According to the DHS, about 60 percent of the CCS treatment base would be subject to the rate reduction. The Administration proposes to continue this rate reduction to June 30, 2006.** (As noted previously, this proposed rate reduction exempts hospital inpatient and hospital outpatient services, as well as supplemental reimbursements, local assistance interagency agreements, services where the non-federal share is provided by means of a certified public expenditure or contract services designated by the Director of Health Services. In addition, FQHC and Rural Health Centers are also exempted.)
- **Implementation of cost containment measures** as proposed trailer bill language, including medical supplies, durable medical equipment, and **drug rebates for blood factor products.**

Subcommittee Request and Questions: The Subcommittee **has requested the DHS to respond to the following questions:**

- Please **briefly summarize** the **key elements** of the May Revision **local assistance proposal.**

Budget Issue: In **addition to the actions already taken by the Subcommittee in its April 21st** hearing, **does the Subcommittee want to (1)** adopt the Administration's revised language regarding drug rebates, ***and*** **(2)** modify the **proposed 15 percent rate reduction?**

If the Subcommittee rejects the proposed 15% rate reduction, a General Fund backfill of $2.1 million is required.

7. Child Health Disability Prevention (CHDP) Program—Public Health Component

Background: Overall Background: The Child Health Disability Prevention (CHDP) Program **provides pediatric prevention health care services to (1)** infants, children and adolescents up to age 19 who have family incomes at or below 200 percent of poverty, and **(2)** children and adolescents who are eligible for Medi-Cal services up to age 21 (Early Periodic Screening Diagnosis and Treatment—EPSDT).

CHDP services play a key role in children's readiness for school. All children entering first grade must have a CHDP health examination certificate or an equivalent examination to enroll in school.

The benefit package provided under the *CHDP-only* program is limited to providing a physical examination, nutritional assessment, vision and dental assessments, hearing assessment, laboratory tests and immunizations. Local health jurisdictions work directly with CHDP providers (private and public) to conduct planning, education and outreach activities, as well as to monitor client referrals and ensure treatment follow-up. With respect to funding, services for

children not eligible for Medi-Cal or Healthy Families are primarily funded with General Fund support.

CHDP Gateway—Budget Act of 2002: Through the Budget Act of 2002 the Administration, working closely with constituency groups and the Legislature, **crafted a Gateway proposal whereby children eligible for the CHDP Program can be pre-enrolled in either Medi-Cal or the Healthy Families Program.**

The purpose of this Gateway was generally two-fold. First it was intended to transition eligible children into the Medi-Cal or Healthy Families Program so comprehensive health care coverage could be provided. Second, it was intended to reduce CHDP expenditures (100 percent General Fund support) and to have children correspond their health care visits with a specified periodicity schedule.

Summary of Development of CHDP Gateway and Implementation: The DHS states that the Gateway **will be up and operational as of July 1, 2003. Many key components have been completed or are on schedule for completion.** System changes to add CHDP Gateway eligibles to the Medi-Cal Eligibility Data System (MEDS) have been proceeding well. CHDP local program training, provider training, and EDS internal system's training are being done or are scheduled. It should be noted that the last date for using the old CHDP paper forms will be September 30, 2003. After this point, everything will operate through the Gateway.

Governor's May Revision (See Hand Out): The Governor's May Revision proposes total expenditures of **$60.5 million** ($50.6 million General Fund, $6.3 million federal Title V funds, and $3.5 million Childhood Lead Poisoning Prevention funds) **which reflects a net increase of $44.5 million (General Fund). Key components of this May Revision include the following:**

- **A 15 percent provider rate reduction for savings of $1.3 million (General Fund), effective October 1, 2003 (versus July 1, 2003 as before).**
- **Continuation of the CHDP hard copy application process for another 6 months (instead of solely using the electronic CHDP Gateway process as of October, 2003) for increased expenditures of over $46 million (General Fund).** (It should be noted that the Medi-Cal Program reflects a corresponding **decrease of about $84 million (General Fund) due to this action.)**

Subcommittee Staff Comment: **The May Revision amount is reflecting a *temporary shift* between the CHDP and Medi-Cal due to the need to continue use of the CHDP hard copy application versus solely using the electronic CHDP Gateway.** The DHS is proposing to continue to use the hard copy application process due to the need for providers to make adjustments. **Originally, hard copy CHDP forms were going to be completely discontinued as of October 1, 2003. Now the DHS wants to continue using them for another 6 months to assist providers. As such, program expenditures are shifting between programs—CHDP and Medi-Cal. The Medi-Cal estimate package reflects a corresponding reduction.**

Budget Issue: Does the Subcommittee **want to adopt the May Revision but make an adjustment for the rate reduction proposal?**

If the Subcommittee rejects the proposed 15% rate reduction, a General Fund backfill of $1.3 million is required.

10. Federal Funds Available for Male Involvement, TeenSMART, and Information & Education Projects via the Family PACT Waiver

Background--Overall: The latest report from the DHS shows birth rates among teens aged 15 to 19 years dropping to their lowest level since 1991. In addition for the first time, birth rates have dropped across all ethnic groups. Further, the abortion rate is on the decline in California, indicating that the efficacy of teen pregnancy prevention programs plays a role in reducing both teen births and abortion**. However, California has the nation's second-highest rate of teen pregnancies.**

California has several, small programs that address various issues and populations regarding abstinence, reproductive education, counseling and outreach that actively promotes behaviors that reduce the risk of pregnancy, as well as addressing additional methodologies for improved access to family planning clinical services by targeting specific populations with unmet needs. **These programs include the Male Involvement Program, TeenSMART, Information and Education Projects, and Media outreach.**

Governor's Proposed Budget: The Governor's January **budget proposes to reduce by a total of $10.3 million General Fund as follows:**

(1) Eliminate the TeenSMART Program which is currently funded at $1.7 million ($848,000 General Fund and $848,000 federal Title XIX funds). This program provides counseling and outreach that actively promotes behaviors that reduce the risk of pregnancy. Based on recent data, about 40,700 total clients were served in 2002 through 25 local projects.

(2) Eliminate the **Teen Pregnancy Prevention Media Campaign for savings of $7.8 million (General Fund);** and

(3) Reduces by $1.7 million (General Fund) the Information and Education Project component designed to decrease teen and unintended pregnancy through proactive prevention education.

These two proposals, coupled with the proposed elimination of the TeenSMART Program significantly impacts the state's efforts to mitigate teen pregnancy, reduce sexual abuse and facilitate responsible parenting. These are core components to the state's overall efforts to mitigate teen pregnancy and to provide assistance to teens who are high risk for abuse.

Subcommittee's Prior Action: In the April 28th hearing, the Subcommittee **(1)** agreed to eliminate the Teen Pregnancy Prevention Media Campaign for savings of $7.8 million (General Fund), **(2)** agreed to reduce by $1.7 million (General Fund) the Information and Education Projects, and **(3)** directed Subcommittee staff to identify resources to restore the Teen SMART Program.

Subcommittee Staff Recommendation: Through technical assistance discussions with the Administration, **it has been determined that the General Fund moneys which would be remaining in these programs, even after the Governor's reduction is taken, could be matched with federal funds through the Family PACT Waiver.**

Specifically, the dollar calculation would be as follows:

- $2.5 million (General Fund) in the Male Involvement Program (existing funding);
- $1.7 million (General Fund) remaining from the Information and Education Projects;
- **Revised Funds available = $8.4 million** ($4.2 million General Fund & $4.2 million federal)
- The **General Fund reduction of $10.3 million**, as contained in the Governor's budget and as already adopted by the Subcommittee, **would remain the same.**

The $8.4 million (total funds) would be appropriated as follows: (1) provide $2.6 million (total funds) for the Male Involvement (same level of funding as current year, plus some funds for contract adjustments)**; (2)** provide $1.7 million (total funds) for the TeenSMART (same level of funding as current year); **(3)** increase the Information and Education Projects by $3.4 million (total funds) (restores their budget year reduction and provides the federal fund match aspect), and **(4)** provide about $700,000 (total funds) for activities associated with collateral materials, education and public awareness that promotes reproductive health, information about the prevention of unintended pregnancies, abstinence, and disease prevention practices to reduce sexually transmitted disease.

Both the Administration and Legislative Analyst's Office agree that these programs can be incorporated within the Family PACT Wavier with minor operational changes.

In order to create the linkage, it is recommended to adopt trailer bill legislation directing the DHS to have the Male Involvement Program and Information and Education Projects contractors modify the scope of work requirements to formally link with the Family PACT Waiver.

Budget Issue: **Does the Subcommittee want to (1)** adopt trailer bill language to direct the DHS to modify the scope of work requirements of the Male Involvement Program and Information and Education Projects to formally link with the Family PACT Waiver, and **(2)** appropriate $8.4 million (**total funds**) **as follows:**

- $2.8 million (total funds) for Male Involvement;
- $1.7 million (total funds) for TeenSMART;
- $2.4 million (total funds) for the Information and Education Projects; and
- $1.5 million (total funds) for activities associated with collateral materials, education and public awareness that promotes reproductive health, information about the prevention of unintended pregnancies, abstinence, and disease prevention practices to reduce sexually transmitted disease.

B. DEPARTMENT OF HEALTH SERVICES- Medi-Cal Program
(Discussion Items)

1. Medi-Cal Baseline Estimate Package

Background on Governor's May Revision: The **Medi-Cal Program local assistance** expenditures for 2003-04 **are estimated to be $22.6 billion ($9.8 billion General Fund),** including the accounting shift. This reflects a net decrease of $633 million (increase of $2.7 billion General Fund), based on the Governor's May Revision proposed policy changes.

Of the proposed **$22.6 billion** amount, **(1)** $20.7 billion is for Medical Care Services, **(2)** $1.571 billion is for County Administration, and **(3)** about $280 million is for the Fiscal Intermediary.

In addition to these expenditures, a total of $4.6 billion (all special funds and federal funds) is provided to fund payments for Disproportionate Share Hospitals, voluntary governmental transfers for supplemental hospital funding and capital debt projects for hospitals.

Subcommittee Staff Recommendation for Baseline Adjustments: The Governor's May Revision **contains the following key baseline adjustments in which the Subcommittee staff has raised no issues.**

A. Deletes the Realignment Proposal: The Governor's January budget proposed to shift about $3 billion in Medi-Cal expenditures, including expenditures for long-term care, to the counties as part of his Realignment package. The May Revision deletes this proposal.

B. Deletes Proposal to Rescind 1931 (b) Medi-Cal Eligibility: The Governor's January budget proposed to **rescind the 1931 (b) Medi-Cal eligibility extension (currently at 100 percent of federal poverty) *and* to reinstate the "100-hour a month work limit".** This proposal would have limited eligibility to families with incomes up to about 61 percent of poverty (annual income of $11,041 for a family of four). With respect to employment, two-parent families would become *ineligible* for Medi-Cal if the principle wage earner works *more* than 100 hours a month (about 23 hours a week), no matter their low-income level. In his May Revision, the Governor deleted this proposal. **As such, the 1931 (b) category of eligibility remains as presently crafted.**

C. Accrual to Cash (with Trailer Bill Language): The May Revision proposes to move the Medi-Cal Program from accrual to a cash budgeting system, the system used by the federal government in funding the state Medicaid programs. Technical trailer bill language is needed for this transaction. This shift is estimated **to produce savings of $930 million (General Fund)** in 2003-04 in the Medi-Cal program. This savings is due to the fact that the payments made to providers after the end of the fiscal year will be budgeted in the year that they are paid versus the year in which the service was provided. **It should noted that the Subcommittee has been advised by the DOF that trailer bill language is needed in order to effectuate this accounting change. It is contained in the Hand Out package.**

D. 3.8 Percent Adjustment to Nursing Home Rates Do To Cost Updates: The May Revision reflects an increase of $51.2 million ($25 million General Fund) to reflect the annual updating of nursing facility and Intermediate Care Facility rates due to cost reports. It should be noted that this rate adjustment is provision and that the annual DHS rate study will be completed in July. At that time, rates will be updated and regulations implementing this rate increase will be promulgated (effective August 1, 2003). **In addition, the DHS notes that further adjustments for increased Worker's Compensation costs may be made if appropriate.**

E. Limitation on Serostim Prescribers: The DHS has revised its policies to specify that Medi-Cal coverage for Serostim (human growth hormone) will be allowed only through prior authorization for savings of $8.9 million (Genera Fund). No trailer bill is required.

F. Emergency Services and Supplemental Payment Funds for Hospitals ("SB 1255"): A total of almost $1.316 billion (special funds) is available to reimburse select hospitals having contracts with the California Medical Assistance Commission (CMAC) to provide enhanced inpatient services. The budget reflects a reduction in payments due to new federal Upper Payment limit restrictions.

G. Medical Education Funds for Teaching Hospitals: A total of $72.4 million (federal funds), is available for certain teaching hospitals for services relating to inpatient clinical teach and medical education activities that are provided to Medi-Cal recipients.

H. Disproportionate Share Hospital Payments: Based on recent federal changes, the revised DSH payment for 2003-04 is anticipated to be $1.8 billion ($903.5 million federal and $903.5 million special fund). The state's allocation remains at $85 million which is used to offset General Fund expenditures in Medi-Cal local assistance.

Subcommittee Request and Question: The Subcommittee has requested the DHS to respond to the following question:

- Please provide ***brief overview*** of the **key baseline items** for the Medi-Cal May Revision.

Budget Issue: Does the Subcommittee **want to adopt the base estimate? This action would align the baseline budget to reflect caseload and all other related adjustments. Other issues, as discussed below, will be discussed individually.**

2. Roll Back the Aged, Blind and Disabled Eligibility

Background: The Budget Act of 2000 **extended "no cost" Medi-Cal eligibility to Aged, Blind and Disabled individuals with incomes up to 133 percent of federal poverty. These individuals have low-incomes but either do *not* qualify for, or choose not to participate in, the SSI/SSP Program.** Currently, individuals can have income of up to $969 per month and couples can have income of up to $1,332 per month and qualify for "no cost" Medi-Cal.

Governor's May Revision: The **Administration proposes to continue their January proposal to roll this expansion back to cover only those eligibles with income up to the SSI/SSP income level or $757 per month for an individual and $1,344 per month for a couple. The budget assumes savings of $99.9 million ($49.9 million General Fund) by eliminating 38,076 aged individuals and 16,190 disabled individuals from "no cost" Medi-Cal.**

Many of these individuals could still obtain coverage under Medi-Cal but they all would need to pay a share-of-cost each month to receive services. This share-of-cost payment would of course be significant for people on fixed, low-incomes. **(The share-of-cost is the amount by which that individual's income or assets exceeds the applicable Medi-Cal limits.)**

Prior Subcommittee Hearing: In two prior hearings, the Subcommittee heard considerable testimony expressing concerns with this loss in eligibility.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please describe what would be a typical share-of-cost for individuals to spend down to become eligible for Medi-Cal if this reduction is effectuated.

Budget Issue: Does the Subcommittee **want to reject this proposed reduction in Medi-Cal eligibility?**

3. Rollback Second Year of Transitional Medi-Cal Coverage

Background and Governor's May Revision: Effective October 1, 1998, California implemented a second year of Transitional Medi-Cal pursuant to trailer bill that accompanied the Budget Act of 1998. Federal Welfare Reform law requires a one-year minimum for coverage.

The second-year of coverage is a state-only program to encourage parents to seek employment and continue their Medi-Cal benefits until they can secure employer paid benefits.

The May Revision continues the Governor's proposal to eliminate the state-only program, leaving the retention of one-year of transitional Medi-Cal coverage. On average 1,834 monthly eligibles are expected to be discontinued. The budget assumes savings of almost $2 million (General Fund) for this purpose.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to briefly explain their proposal.

Budget Issue: Does the Subcommittee **want to adopt the proposal to delete the second year of Transitional Medi-Cal?**

4. Proposed Elimination of "Optional" Benefits

Background Overall—What are Optional Benefits: The term **"Optional Benefits" is in reference to how federal law and regulation defines the service.** Under federal law, **certain medical services are required to be provided by states while others are provided at the state's "option"**. **The federal government mandates 13 services including:** inpatient hospital (excluding mental disease), outpatient hospital including certain clinics, physicians' services, pregnancy related services, X-Ray, laboratory testing, nursing home and home health care, family planning, and a few others.

As noted in *Health Affairs* (volume 22, number 1, 2003), the comprehensive nature of Medicaid benefits is often misunderstood. The breadth of covered services reflects the complex needs of the disabled, aged, blind, mentally ill, medically needy children and pregnant women populations. Medi-Cal only reimburses for those "optional" services that are provided to individuals as a service.

Governor's May Revision: The **May Revision assumes revised savings of $419.4 million ($209.7 million General Fund) from the elimination of specified Medi-Cal Optional Benefits, effective as of October 1, 2003 (was July 1, 2003)**.

Children, services to ensure the health of pregnant women, individuals residing in nursing homes, and family planning services and dental services that could be provided by a physician, whether provided by a physician or a dentist, are all protected from this proposed elimination.

However, individuals with developmental disabilities would not be exempt from the Administration's proposal. As such, Regional Centers would need to purchase these benefits for individuals with developmental disabilities at 100 percent General Fund expenditure, in lieu of obtaining partial matching federal funds. **The Department of Developmental Services budget for May Revision reflects an increase of $47.2 million General Fund for this purpose.** (The DDS budget will be discussed in the May 23rd Subcommittee hearing on Friday.)

As noted in the *table below*, Van Transportation and Hospice care cannot be eliminated based upon further discussion with the federal Centers for Medicare and Medicaid (CMS). The elimination of Prosthetics and Orthotics benefits were also deleted from the May Revision. The Independent Rehabilitation item was removed for it pertains to a provider-type, not a benefit per say.

Optional Benefit Category (Proposed to Eliminate)	Governor's January Proposal (General Fund Savings) (July 1 deletion)	Governor's May Revision (General Fund Savings) (Oct 1 deletion)
Adult Dental Services	$211.8 million	$129.2 million
Medical Supplies (diabetic supplies, IV supplies, wound care, asthma supplies, contraceptive supplies)	54.3 million	20.1 million
Van Transportation	31.5 million	Can't eliminate per fed gov
Hospice	13.7 million	Can't eliminate per fed gov
Durable Medical Equipment	12.5 million	19.1 million
Optician and Laboratory Services	14.5 million	6.5 million
Optometry	9.2 million	2 million
Podiatrist	4.3 million	2 million
Acupuncture	2.9 million	3.8 million
Prosthetics	2.1 million	Deleted from proposal
Hearing Aids	**2.9 million**	**5.9 million**
Psychologist	229,000	415,000
Chiropractor	399,000	286,000
Independent Rehabilitation Facility	23,000	Deleted from proposal
Occupational Therapy	15,000	89,000
Physical Therapy	30,000	140,000
Orthotics	640,000	Deleted from proposal
Speech and Audiology	728	2.3 million
Managed Care Adjustment		17.5 million
TOTAL GF SAVINGS	**$361.8 million**	**$209.7**

Subcommittee Request and Questions: The Subcommittee **has requested the DHS to respond to the following questions:**

- **1.** Please **explain the key differences** from January.

Budget Issue: Does the Subcommittee want to propose any adjustments to the May Revision regarding the elimination of Optional Benefits as shown above?

5. Intermediate Care Facilities for the Developmentally Disabled (ICF-DD Facilities) *(A)* Proposed 15% Rate Reduction *& (B)* Quality Assurance Fee

Background—What Are ICF-DD Facilities and How are They Paid: Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) are health facilities licensed (state requirements) and certified (federal requirements) by the Department of Health Services to **provide 24-hour per day care**. **Generally, ICF-DD facilities provide assistance to individuals with significant medical needs.**

Based on information provided by the DHS, there are a total of **964 ICF-DD facilities in California of which 957 are "privately-operated" facilities and seven are state-operated (i.e., the Developmental Centers).**

ICF-DD facilities are unique from other long-term care nursing facilities in that the clients who receive services are almost always enrolled in Medi-Cal. As such, there is no other third-party reimbursement available—the facility is reliant on Medi-Cal reimbursement.

According to the DHS, the average daily rate reimbursed by Medi-Cal is $166 per patient per day for privately-operated facilities and $524 per patient per day for the state-operated Developmental Centers.

Governor's May Revision--Continues 15 Percent Rate Reduction: The May Revision continues the Governor's January proposal to reduce ICF-DD Facility rates **by 15 percent**, but the effective date has moved back to **October 1, 2003** due to state requirements regarding provider notification of rate changes (versus July 1, 2003 as previously proposed). **The May Revision assumes savings of $50.9 million ($25.7 million General Fund) from the rate reduction. State-operated Developmental Centers would not have their rates reduced at all.**

Governor's May Revision—Quality Assurance Fee: The May Revision continues the Governor's January proposal to require ICF-DD facilities and state Developmental Centers **to pay the state a Quality Assessment Fee of 6 percent on the total rate per patient day. This assessment amount would then be used by the state to obtain a portion of federal matching funds. A portion of these new federal funds would be used to offset General Fund expenditures and to provide for a rate adjustment to ICF-DD facilities. It should be noted that several other states have implemented similar programs for their ICF-DD populations.**

The Quality Assessment Fee would be a per diem "add-on" to the regular reimbursement rate and would be added for each patient day during the quarter. **This add-on would be computed to return at least 100 percent of the fee paid by the facility at the end of the particular quarter.**

Under the Administration's proposal, the following would occur:

• **15% Rate Reduction** Taken from ICF-DD Facilities	$25.7 million General Fund
• ICF-DD Facilities Pay Fee (Fees placed into General Fund)	$52.5 million Fee Amount
• Fee used to obtain a federal match	20.5 million federal funds
• ICF-DD Facilities Paid Rate Increase (above the fee amount)	$5.9 million (above fee)
• Total Savings to the **General Fund from Quality Assurance**	$14.6 million
• **Total General Fund Savings**	**$40.3 million General Fund**

Subcommittee Staff Recommendation: It is **recommended to (1) enact the Quality Assurance Fee, *and* (2) reject the 15 percent rate reduction.**

If the Subcommittee rejects the 15 percent rate reduction, **then (1)** the General Fund savings for the Quality Assurance Fee proposal increases by about $940,000 for total General Fund savings of $15.5 million, and **(2)** the **increased cost to the General Fund to backfill for the rate reduction is $25.7 million.**

Several other states use this federally approved mechanism to draw additional federal funds and the ICF-DD facilities could use the rate increase since they are nearly 100 percent reliant on Medi-Cal for payment.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please **briefly explain *any key* differences** between the May Revision proposal—rate reduction and Quality Assurance Fee—and the January budget.

Budget Issue: Does the **Subcommittee want to (1)** adopt the Quality Assurance Fee proposal, and **(2)** reject the rate reduction proposal?

6. Medi-Cal Managed Care Program— *(A)* Proposed 15% Rate Reduction *&* *(B)* Proposed Quality Assessment Fee, *(C)* State Staff *(All to be discussed jointly)*

Background—Managed Care Plans and Rates: California utilizes several Medi-Cal Managed Care models for the delivery of health care services, including County Organized Health Care Systems (COHS), the Two Plan model (local initiatives and commercial HMOs), and Geographic Managed Care. The DHS **presently contracts with 31 health plans, many of which are considered *non-public* agencies.**

Under both state and federal requirements, the capitation rates paid under a managed care model must be below the fee-for-service cost equivalent. **The rates paid to Medi-Cal Managed Care plans have been frozen for the past two years.**

Generally, managed care rates must be based on an actuarial basis and are to be no more than 99 percent of the fee-for-services base. For the County Organized Health Care Systems (COHS), the California Medical Assistance Commission (CMAC) negotiates rates based upon confidential expenditure and cost information.

Background—Federal Law Regarding Quality Assessment Fees: **Under the authority of the Social Security Act, Title 19, Section 1903(w)(7)(A), the state may impose a "Quality Assessment Fee"** on managed care contracts providing services under the Medicaid Program (Medi-Cal in California). **This mechanism can be used to then draw down additional federal funds.**

Governor's May Revision—15 Percent Rate Reduction: The May Revision continues the Governor's January proposal to reduce Medi-Cal Managed Care rates **by 15 percent**, but the effective date has moved back to **October 1, 2003** due to state requirements regarding provider notification of rate changes (versus July 1, 2003 as previously proposed). **The May Revision assumes savings of $ 380 million ($190 million General Fund) from the rate reduction.**

Governor's May Revision—Implements a Quality Assessment Fee: The **May Revision proposes to implement by *January 1, 2004*, a quality assessment fee for Medi-Cal Managed Care plans as allowed for in federal law. Under this proposal, the DHS would assess a Quality Assessment Fee of 6 percent on all Medi-Cal Managed Care plans. The amount actual paid by each plan would vary, depending on their gross Medi-Cal revenue.**

The Quality Assessment fee would then be used to (1) obtain increased federal funds to provide a rate adjustment for Medical Managed Care plans, and (2) obtain increased funds to offset about $37.5 million in General Fund support.

Based upon information provided by the DHS, the fiscal arrangement would be as follows:

- **6 percent fee paid by the plans** =$150 million in revenues
- **State uses 25 percent of $150 million to backfill for GF** **=$37.5 million (GF savings)**
- **State obtains federal match on remaining $112.5 million** =$225 million available for use
- **State provides plans with rate adjustment** =$225 million
- ***Net* amount** (6% fee paid versus rate adjustment) **to the plans** =$75 million (net gained--plans)
- **The DHS will need to modify the state's existing Medi-Cal "Upper Payment Level" in order to make these funds available to the plans.** The DHS would then distribute the "Upper Payment Level" amount to the various Two-Plan Model entities based on the existing DHS rate model that recognizes the cost of providing services in the county, and the plans acuity mix. For Geographic Managed Care Organizations and County Organized Health Care Systems (COHS), the California Medical Assistance Commission (CMAC) would allocate the funds through their existing contract process. In addition, the AIDS Health Care Foundation (as a primary care case management entity) would also be included in the quality assessment fee process.

As noted in the Hand Out, trailer bill language is needed to effectuate the Quality Assurance proposal.

Governor's May Revision—Request for State Staff: Through a Finance Letter, the DHS is requesting **an increase of $196,000 ($97,000 General Fund) to fund three DHS positions to implement the proposal.** Specifically, the DHS is requesting two Account I Specialists and one Account Officer to conduct activities associated with Quality Assessment Fee implementation.

The LAO recommends making one of the Account I Specialists a two-year limited-term appointment.

Subcommittee Staff Recommendation: This proposed Quality Assessment Fee for Medi-Cal Managed Care plans parallels the Administration's proposal for implementing a Quality Assurance Fee for Intermediate Care Facilities--Developmentally Disabled (ICF-DD) which the Subcommittee has already reviewed. **Several states have been using Quality Assessment fees to assist in making Medicaid program improvements for several years.**

It is recommended to (1) adopt the Quality Assessment Fee proposal, including the proposed language (as placeholder language to enable technical adjustments to be incorporated, if needed, after working with the industry), ***and*** **(2)** approve the DHS positions but designate the Account I Specialist as a two-year limited-term appointment.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please **briefly describe the 15 % rate reduction. Will all of the 31 contracted health plans receive an across-the-board reduction or what?**
- **2.** Please **briefly describe** the proposal to implement a **Quality Assessment Fee** for Medi-Cal Managed Care plans.
- **3.** How would the **Quality Assessment Fee impact with the proposed rate reduction? (In essence, what level of net rate adjustment is there with the Quality Assurance Fee?)**
- **4. Generally, how would the Quality Assessment Fees be collected from, and then allocated back, to the plans?**
- **5. Are the three requested positions to be funded from the revenues obtained from the Medi-Cal Managed Care plans (along with the federal match) or are they funded using the portion of revenues the state receives as a General Fund backfill?**

Budget Issues: **Does the Subcommittee want to take action on the following items:**

- Modify the Governor's proposed 15% rate reduction?
- Adopt the Quality Assurance Fee?
- Make any modifications to the proposed trailer bill language regarding the Quality Assurance Fee?
- Approve the three requested state positions, but make one a two-year limited-term appointment?

7. Proposal to Reduce Medi-Cal Fee-For-Services Rates by 15 Percent

Governor's May Revision: The May Revision continues the Governor's January proposal to reduce Medi-Cal rates **by 15 percent**, but the effective date has moved back to **October 1, 2003** due to state requirements regarding provider notification of rate changes (versus July 1, 2003 as previously proposed). **As noted in the table below, the May Revision assumes savings of $814.1 million ($404.3 million General Fund).** This reflects a reduced savings level of about $316 million (General Fund) when compared to the Governor's January budget. This is primarily attributable to the later implementation date.

Trailer bill **legislation would continue the reduction for three years through 2005-06 (ending as of July 1, 2006). The proposed trailer bill legislation would also provide the Director of the DHS authority to identify in regulations *other* programs in which providers shall be paid rates of payment that are identical to the rates paid under Medi-Cal.**

The following table summarizes the May Revision rate reduction for 2003-04. ***(Reductions are also proposed for ICF-DD Facilities, Family PACT and Managed Care plans. These are discussed later in the agenda.)***

Medi-Cal Service Category	Governor's May Revision 2003-04 (October 1, 2003) (15 percent) (General Fund Savings)
Nursing Home Facilities	$189.7 million
Physicians Services	54.6 million
Other Services (adult day health, hospice, hearing aids, AIDS waiver, and others)	27.2 million
Other Medical Services (podiatry, occupational therapy, acupuncture and others)	38.9 million
Pharmacy Services	24 million
Dental Services	26.7 million
Home Health	8.9 million
Early Periodic Screening Diagnostic and Treatment (EPSDT) Services	1.6 million
Medical Transportation	7 million
TOTAL SAVINGS	**$378.6 million**

Sub committee Staff Comment: There is evidence that the rates paid to providers could affect access to health care and the quality of care to patients. A recent national analysis of Medicaid physician rates by The Urban Institute concluded that physician fee levels affect both access and outcomes for Medicaid patients.

A Pricewaterhouse study completed last year found that, even after accounting for the rate increase provided in 2000, Medi-Cal rates continue to lag behind those of other purchasers of health care coverage in California. Another study released last year found that while the 2000 Medi-Cal rate increases were substantial, they collectively only brought the Medi-Cal provider rates from 58 percent to 65 percent of California's average Medicare payment rates.

This is the first time that nursing home facilities have been included in a rate reduction. Inclusion of nursing homes is particularly problematic due to staffing standards and wage requirements, federal regulations, and the industry's dependence on Medi-Cal payments (two-thirds of the over 1,500 nursing homes depend on Medi-Cal reimbursement). In addition, a State Plan Amendment would be required since the federal government requires these rates to be developed on an annual basis through a methodology contained in the state's Medicaid State Plan.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please **briefly** describe the changes in the proposal.

Budget Issue: Does the Subcommittee **want to modify the proposal?**

8. Family PACT Proposed 15 Percent Provider Rate Reduction

Background Current Family PACT Program: **One of the state's most cost-beneficial programs** is the Family PACT Program. Through the Budget Act of 1996, a state-only family planning program— Family PACT—was enacted to expand access to family planning services.

California operates this program under a federal Medicaid Waiver. As such, the state can draw an enhanced 90 percent federal match for many services, as well as a 50 percent federal match for most other services.

Generally, women and males with incomes at or below 200 percent of poverty who have no other source of health care coverage have access to comprehensive family planning services (abortions and services ancillary to abortions are ***not*** funded under Family PACT). Program participants are screened and enrolled by approved Medi-Cal providers, including both public and private entities, on site.

As currently structured, the Family PACT among other things provides reimbursement for patients who are seeking (1) contraceptive services, (2) pregnancy testing, and (3) reproductive health education and counseling services.

The **services currently covered** under the Family PACT **include**:

- Reproductive health information, education and counseling services;
- General reproductive health care and preventive services limited to cancer screening and sexually transmitted infections (including HIV);

- Medical family planning services;
- Preconception counseling; and
- Sterilization services.

Governor's May Revision: The May Revision **proposes savings of $49.6 million ($13 million General Fund) by reducing Family PACT by 15 percent as of October 1, 2003 (versus July 1, 2003 as previously proposed). Due to the availability of enhance federal funds (up to a 90 percent federal match for many services), this proposed reduction only achieves a 26 percent General Fund savings level.**

The following chart shows the reduction by service category:

Category	Total Fund Savings	General Fund Savings
Physicians	$10.4 million	$2.7 million
Other Medical	$28.6 million	$7.5 million
Drugs	$10.6 million	$2.8 million
Totals	**$49.6 million**	**$13 million**

Budget Issue: Does the Subcommittee want to modify the proposal?

9. Adult Day Health Care Centers—(A) Moratorium, (B) Unbundled Rate, (C) Request for State Staff, *and* (D) Alternative Proposal (Discussed Together)

Background—What is Adult Day Health Care: Adult Day Health Care (ADHC) is **a community-based day program which provides nursing, physical therapy, occupational therapy, speech therapy, meals transportation, social services, personal care, activities and supervision designed for low-income elders and younger disabled adults who are *at risk* for being placed in a nursing home.**

ADHC has been a successful model for elderly individuals for they can obtain many services in one location. For these individuals, particularly those with mobility challenges, going to one place for health care results in better compliance with therapy, medication, nutrition, and exercise regimens. **Under Medi-Cal, individuals can participate in ADHC from one to five days per week, but usually average about three days a week.**

The general concept behind providing ADHC services is that they delay or defer individuals from going into nursing homes or other more costly forms of care and therefore, it saves Medi-Cal money. Compared to the monthly Medi-Cal cost of a nursing home at about $3,400 per month, ADHC can cost as much as three to four times less.

Background—How is ADHC Eligibility Determined: There **is a formal intake and assessment process** to initially determine whether an individual would benefit from the ADHC services. If an individual is accepted for enrollment into the ADHC, a team meeting is convened and **an Individual Plan of Care is crafted.**

All individuals attending ADHC must be approved by a Medi-Cal field office using a "treatment authorization process (TAR) in order for the ADHC facility to receive Medi-Cal reimbursement for the individual.

Background—ADHC Facility Application Process: In order to become an ADHC provider, there are many steps that are required to be met, including the following:

- Complete a prospective **Provider Application** and submit to the state in order to obtain licensing and certification approval (DHS and CDA reviews).
- **Obtain a facility site and secure qualified staff** in preparation of obtaining approval.
- Undergo a local planning council review to ensure if there is a need in the service area.
- **Field work is completed by the state and licensing and certification is approved.** The applicant is now a certified Medi-Cal provider.

Background—How is the ADHC Funded: The ADHC Program (about 300 ADHC Centers) **is funded through Medi-Cal.** Based on the Governor's May Revision, **California is slated to expend $305.3 million ($152.6 million General Fund) in 2003-04. This DHS fiscal project assumes the following:**

- Average cost per participant is about $777 per month **(about $68.57 per day per recipient)**.
- Total actual participants as of June 2002 is 22,411 participants.
- Total projected participants as of June 2003 (beginning of the 2003-04 budget year) is about 29,000.
- Total projected participants as of June 2004 (end of the 2003-04 budget year) is about 36,000.

Recent Concerns with ADHC Growth: **Both the DHS and the California Association for Adult Day Services (Association) have noted that the ADHC Program began to grow** in 1999 after many years of exceedingly slow growth. ***Generally*, some of the reasons for this growth included: (1)** changes in the state's aging and immigrant demographics, and **(2)** the lifting of statutory restrictions against "for profit" ADHC providers. The area of most rapid growth has been in Los Angeles County where there are larger concentrations of Medi-Cal recipients (about 28 percent or so statewide).

Prior Subcommittee Hearing: In the May 12th hearing, the Subcommittee discussed the concept of placing a moratorium on Adult Day Health Care, and the California Association for Adult Day Services presented their proposal for managed growth**. Information from this hearing was taken under consideration, and the LAO was asked to conduct a fiscal analysis of the CA Association for Adult Day Services option.**

Summary of Governor's May Revision: The DHS **is proposing to implement significant changes to Adult Day Health Care through the May Revision for proposed savings of $19.8 million ($9.9 million General Fund) in local assistance, *and* increased costs of $904,000 ($247,000 General Fund) in state support to fund nine new state positions.**

The key aspects to the Administration's proposal are (1) impose a moratorium for one-calendar year, **(2)** un-bundle therapies and transportation from the per diem rate, ***and* (3)** a rate reduction of 15 percent as of October 1, 2003. ***(The rate reduction for ADHCs equates to $34.3 million ($17.2 million General Fund) and was addressed under issue 7 of the agenda, above.)***

Specifically, the proposed DHS changes to ADHC Centers are as follows:

- Trailer bill legislation to **"de-link" the licensing and certification** of ADHC Centers.
- Place a **moratorium on certification** (related to Medi-Cal reimbursement) ***and* enrollment of new ADHC Centers, and certification for increased capacity in existing ADHC Centers** for at **least one calendar** (not fiscal) **year**, **with extension of the moratorium as determined by the DHS Director.**
- **Un-bundle the current bundled per diem Medi-Cal rate** to ADHC Centers.
- **Remove therapies** (physical, occupational and speech), **and recipient transportation** (to and from centers) from the Medi-Cal reimbursement rate.
- "Re-bundle the remaining required ADHC Center services into a lower bundled per diem reimbursement rate.
- Allow the ADHC Centers to bill separately for the therapies and transportation on those days such services are authorized and provided to recipients.

The May Revision savings are assumed to be as follows:

- Moratorium for one-calendar year (***without*** 15% rate reduction-Oct 1, 2003) $3.7 million GF
- Moratorium for one-calendar year (**with** 15% rate reduction-Oct 1, 2003) $3.2 million GF
- Un-bundling of rate (***without*** 15% rate reduction) $8.1 million GF
- Un-bundling of rate (**with** 15% rate reduction) $6.9 million GF
- **Total Savings—moratorium & un-bundling** (***without*** 15% rate reduction) $11.6 million GF
- **Total Savings—moratorium & un-bundling** (**with** 15% rate reduction) $9.8 million GF

California Association for Adult Day Services—Option for Managed Growth: The Association has crafted a proposal **which is intended to (1)** strengthen ADHC services as a community-based alternative to institutional placement (such as nursing homes) **(2)** modernize the licensing and certification process, and **(3)** strengthen authority for planning and prioritizing new ADHC sites. Through this proposal, the Association intends to manage and control the growth of new sites..

Key aspects of the Association's proposal includes the following:

- **Creates a "Pre-Certification" Process:** This process would **(1)** require the Applicant to attend a **mandatory orientation course** offered by the state (CDA) or a contractor prior to obtaining and submitting an application; **(2)** require the Applicant to submit their application **along with a letter detailing the need for the services** in the geographic area; **(3)** require the CDA to conduct a face-to-face interview with the Applicant. Under this process, the CDA will have authority to prioritize applicants based on need factors and the department's estimation of the providers readiness. The CDA would notify the applicant of the potential timeframe for application processing.
- **Then Proceed with Facility Licensing:** After the Pre-Certification is complete, the Applicant would comply with the remaining requirements for the licensing process, including the identification of the facility site, submission of fingerprint cards and all health and safety rules. The Applicant would then proceed through the regular DHS licensing field office inspection.
- **Provides for an Updated Fee Schedule:** Generally, this component of the proposal would increase fees for initial applications and licensing renewals. **According to calculations provide by the Association, increased revenues of about $800,000 would be generated.** It is assumed that some of these funds would be used by the California Department of Aging (CDA) to offset any additional expenditures due to the above outlined changes.
- **Provides for a Six-Month Moratorium:** Under this moratorium, applicants "in-the-pipeline" who are currently proceeding with licensure and certification can continue, but a moratorium would then be put into place for the new "managed growth" process to then be implemented.

The Association maintains that by placing requirements up-front, it will improve the application process, slow the growth of demand in areas that may not have a fully identified need for the services, and is an overall better use of state resources.

Legislative Analyst's Office—Summary of Cost Review: The LAO states that they believe the Association's proposal would not result in savings to the state in 2003-04, **but would result in total savings of $10.8 million ($5.4 million General Fund) in 2004-05 *(assumes no rate cut)*. These savings would grow in the subsequent year to about $20.2 million ($11.1 million General Fund).**

Overall, they note that the Association's proposal is a reasonable alternative.

Subcommittee Staff Recommendation: It is recommended **to reject the Administration's moratorium and un-bundling proposals.** (The 15 % rate reduction was already addressed under agenda item 7, above) The problem that the Administration is trying to address remains unclear. Expansion of service providers is not in and of itself, a reason for a moratorium. If the Administration is concerned about unscrupulous providers then changes to licensing and certification, similar to what the Association is proposing, could mitigate concerns and be a more efficient use of staff resources (i.e., screening providers up-front).

It is further recommended to adopt *in concept*, the Association's proposal to **(1)** adopt placeholder trailer bill language to provide authority for the new "managed growth" application process (including its various component parts), **(2)** adopt uncodified trailer bill language for the DHS to give notice of a 6-month moratorium on accepting new applications, and a 30-day notice to end the moratorium and announce the new process, and **(3)** adopt new licensing fee schedule, including an initial application fee of $5,000 and a renewal fee based on licensed capacity at $20 per person.

Subcommittee Request and Questions: The Subcommittee has requested the DHS, LAO and Association to respond to the following questions:

- **1.** DHS, Please briefly present the Administration's proposal.
- **2.** Association, Please briefly present your alternative proposal.
- **3.** LAO, Please comment on your cost analysis.

Budget Issue: Does the Subcommittee want **to adopt the Subcommittee staff recommendation as referenced above to (1) reject the Administration's proposal regarding the moratorium and unbundled rate, and (2) the component parts of the Association's proposal as noted above under the staff recommendation?**

10. Disease Management

Background: **Existing state statute defines "disease management programs and services"** as services administered **to patients in order to improve their overall health and to prevent clinical exacerbations and complications utilizing cost-effective, evidence-based, or consensus-based practice guidelines and patient self-management strategies.**

Existing statute defines a "disease management organization" as an entity that provides disease management programs and services, which contracts with any of the following: a health care service plan; a contractor of a health care service plan; an employer; a publicly financed health care program, or a government agency.

Disease management can improve the quality of life of patients by catching health-related problems early, enabling patients to subsequently avoid high cost medical treatments and procedures—especially those associated with hospitalizations. **Evidence of the efficacy of these programs has been shown for a variety of chronic conditions including diabetes, coronary artery disease, chronic obstructive pulmonary disease, asthma, renal disease and other chronic illnesses. The expansion of disease management programs is a nationwide trend.** eligible populations with chronic disease. **In addition, CalPERS is moving to implement a disease management program as well this upcoming year.**

It should also be noted that SB 323 (Soto) has been introduced to require the DHS to develop a strategy for providing Medi-Cal recipients with population-based disease management programs and services, and to seek all necessary federal CMS Waivers that would be needed to implement such a program.

Finally, it should be noted that Medi-Cal will expend about $13.7 million (total funds) on about 1.5 million Aged, Blind and Disabled Medi-Cal eligibles in the current-year. Many of these eligibles could be enrolled in a disease management program, if available.

Governor's May Revision: The May Revision requests **an increase of $756,000 ($279,000 General Fund) to support 7 new state positions. No local assistance savings are anticipated from this proposal until 2005-06 due to the need to design a program, identify Medi-Cal patients, enter into contracts with one or more providers and other related factors.**

The DHS states that many key issues will need to be addressed via the Request for Application and contracting process in order to implement a Disease Management Program.

The 7 new positions include the following: Medical Consultant I; two Nurse Consultant II; two Associate Governmental Program Analysts; one Staff Services Manager I; one two-year limited-term Associate Governmental Program Analyst.

The Administration is also proposing trailer bill language to (1) apply for a federal Waiver (which is required for this program to operate), **(2)** limit the number of participants in the program during the initial three-years of operation, **(3)** obtain contract authority, **(4)** implement

the program contingent upon appropriation for this purpose, **(5)** conduct an evaluation of the program, and **(6)** provide the evaluation to the Legislature by January 1, 2008

Subcommittee Staff Recommendation: Implementation of Disease Management in Medi-Cal makes sense from a recipient health care perspective, as well as from a restructuring perspective to control hospital inpatient expenditures and overall expenditures due to chronic, yet often manageable conditions. **However the number of the positions are not justified given the state's fiscal condition, as well as the need to more thoroughly define what the state is going to be doing versus what may be completed by expert consultant staff.**

In addition, after reading the DHS workload analysis justification for each of the requested classifications, it is evident that more analysis needs to be done to better discern how the unit is going to operate and how the program is going to be designed. **Further, additional positions can always be added next year, if more thoroughly justified.**

As such, it is recommended to provide funding for a total of three positions and corresponding operating expenditures. Two of the positions would be for the Medi-Cal Policy Division (i.e., the Medical Consultant I and one Nurse Consultant II), and one position would be for the Office of Medi-Cal Procurement.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- Please **briefly describe the Disease Management proposal**.

Budget Issue: Does the Subcommittee want to modify the request for the positions?

11. Proposed Changes to Medi-Cal Drugs--ISSUES "A" to "B"

Overall Background On Medi-Cal Drug Program: Nationwide pharmaceutical costs **are one of the fastest growing components of all health care.** Generally, the growth is mainly due to technological advances in, and cost of, the development of new pharmaceutical products. Numerous states have recently enacted changes to their Medicaid Programs in order to control costs.

California has historically had one of the least expensive Medicaid pharmaceutical programs in the nation. **The Medi-Cal fee-for-service Drug Program controls costs through two major components—(1) a Medi-Cal List of Contract Drugs (or formulary), and (2) contracts with about 100 pharmaceutical manufacturers for supplemental rebates. Drugs listed on the formulary are available without prior authorization. In turn, the manufacturers agree to provide certain rebates mandated by both the federal and state government.**

The state supplemental drug rebates are negotiated by the DHS with manufacturers to provide additional drug rebates above the federal rebate levels. The Governor's May Revision estimates that **the baseline *state supplemental rebates* will save $366.2 million ($183.1 million General**

Fund). With respect to the *federal rebates*, the budget assumes savings of $986.8 million ($491.8 million General Fund).

In total, the Governor's May Revision assumes expenditures of $2.815 billion ($1.4 billion General Fund) for drug expenditures in Medi-Cal.

The Budget Act of 2002 made substantial changes to the program. Some of these changes are still being implemented.

Bureau of State Audits Report and Subcommittee Request: The Bureau of State Audits (BSA) just released (April 30, 2003) a comprehensive audit regarding the Medi-Cal Drug Program. It contains considerable recommendations regarding program improvements, including all of the items to be discussed below.

Prior Subcommittee Hearing: In the May 12th hearing, the BSA and DHS discussed several issues regarding potential improvements which the state could undertake. The Administration's May Revision proposes several of these.

ISSUE "A"—Collection of Aged Rebates Owed

Background: Collection of manufacturer rebate moneys owed to the state has been a long standing issue with the DHS. In a 1996 report, the Bureau of State Audits (BSA) identified about $40 million in past, owed rebates to the state. **As note in the BSA April 2003 report, the "aged rebates" owed to the state has escalated to be $216 million.**

The Budget Act of 2002: The Budget Act **(1)** provided four new staff to assist in processing aged rebates, and **(2) enacted trailer bill legislation to prevent the loss of state drug rebates if manufacturers recalculate downward their average manufacturers price (AMP) or their "best price" as defined in federal law.** This was done because California was losing rebate dollars due to manufacturers retroactively making changes, and therefore, reducing rebates.

The DHS also was provided with resources to implement the Rebate Accounting and Information System (RAIS) through its contract with the Fiscal Intermediary (EDS). **Using the RAIS, the DHS can now automatically bill and track the collection of state and federal rebates due from manufacturers.**

Governor's May Revision: The May Revision **is requesting an increase of 11 staff** –ten Associate Governmental Program Analyst's and one Staff Manager I-- to conduct numerous activities associated with collecting aged rebates. The DHS is requesting for all of these positions to be made permanent.

The DHS states that $29.5 million ($14.7 million General Fund) can be achieved in 2003-04 from this activity.

Subcommittee Staff Recommendation: The **BSA audit noted three key items**. **First,** the DHS was letting some **state supplemental rebates inadvertently expire** and thereby, costing the state some rebate savings. Providing these positions and using the fully implemented RAIS should help mitigate this from happening in the future. **Second,** the BSA had identified very real problems with hiring Pharmacy staff (due to severe shortages). Since these are Associate Governmental Program Analyst's that will be doing the aged rebate work (versus Pharmacists), they should be easier to hire and therefore, quicker to bring-on-board.

Third, the DHS is responding to the BSA issue of working with the federal government to fully implement the trailer bill legislation implementing the Budget Act of 2002 safeguards regarding the potential for changing rebate amounts.

The DHS has informed the Subcommittee that the local assistance savings level assumes that only 20 percent of the aged rebates will be collected. **However, the BSA has identified $216 million (as of April 1, 2003) and growing. In addition, as referenced above, the DHS will be obtaining not only increased staff resources, but better tools (such as a fully implemented RAIS and federal assistance on protecting rebates) to attack this problem in the budget year. The expectation of success should be raised. Therefore, it is recommended to increase the May Revision savings level by an additional $20 million General Fund assuming the BSA figure of aged rebates owned and a success factor of closer to a 35 percent collection rate.**

Budget Issue: Does the Subcommittee want to adopt the recommendation to **(1)** approve the positions on a **three-year limited-term basis**, and **(2)** assume **increased savings of $40 million ($20 million General Fund) above the Governor's May Revision amount?**

ISSUE "B"—Therapeutic Category Reviews (TCRs)

Background: Drugs **are organized into therapeutic categories, such as antibiotics**, or drugs that treat hypertension for example. According to the DHS, there are as many as 114 of these therapeutic categories, depending on one's categorization.

The DHS has conducted several TCRs over the years which have resulted in considerable savings. In essence, a TCR assesses the cost-effectiveness of all drugs in a therapeutic or chemical drug classification. **The BSA Audit noted that the DHS needs to conduct more reviews and that considerable savings could be achieved through this process.**

Under the TCR process, the Medi-Cal Advisory Committee evaluates the drugs within a category (such as nonsteroidal anti-inflammatory) using criteria including safety, effectiveness, essential need, cost and misuse potential. Based on this evaluation, the Committee makes recommendations to the DHS on which drugs should be included on the formulary. The DHS then reviews these recommendations, obtains input from the manufacturer's of the drugs, reviews cost data, considers other sources of information and then submits recommendations for TCRs to the Director of the DHS for a final determination. **Drugs**

can then be added or deleted from the List of Contract Drugs. This review compares each drug in that category against every other drug at the same time.

The DHS notes that because of new drugs coming onto the market, changing market share and changing market costs, **a TCR should be conducted about every three years** in order to help stay current and maintain good prices/rebates for drugs on the List of Contract Drugs.

Governor's May Revision: The May Revision is requesting **an increase in state support to hire three Pharmacy positions to conduct four additional TCRs *annually*.**

The May Revision assumes budget year savings of $32 million ($15.5 million General Fund). It should be noted that most of these savings--$14.8 million GF—are attributable to increased rebates.

The DHS believes there are 12 TCRs that would yield the largest savings. The one-time savings taken over the first 12-months following TCR completion for each of the four TCRs to be performed is estimated to be 10 percent of the 2002 expenditures. **These are listed below:**

- TCR #1 "Statin" drugs for hypercholesterolemia — $8.1 million GF savings
- TCR #2 "ACE" inhibitors (cardiac drugs) **and** Angiotensin converting — $6.2 million GF savings
- TCR #3 Non-sedating antihistamines — $2.9 million GF savings
- TCR #4 Quniolone antibiotics — $1.7 million GF savings
- Additional TCR will be selected for review during the fist year **(DHS notes that this is a placeholder and *is conservative*)** — $1.5 million GF (per)

Subcommittee Request and Questions: The **Subcommittee has requested the DHS to respond to the following questions:**

- **1.** Please **briefly describe** the proposal and the savings levels.
- **2.** What would be the next category. or categories, that would make sense to under go a TCR?

Budget Issue: Does the Subcommittee **want to modify the proposal in any manner?**

12. Pharmacy Cost Savings--(1) Step-Care Therapy Program, (2) Direct Prescriber Communications, (3) Enhanced Educational Programs, (4) Face-to-Face Interventions

Background—(1) Step-Care Drug Therapy Program: A step-care drug therapy program encourages the use of effective, less expensive drugs before more expensive drugs.

Background—(2) Direct Prescriber Communications: This is a program to provide feedback directly to doctors and other prescribers on the appropriate use of expensive drug therapy.

Background—(3) Enhanced Education Programs: The DHS would provide educational information to doctors (such s the Atypical Antipsychotic Program) to influence doctors' to consider the cost of drug therapy in their prescribing habits.

As part of the May Revision proposal, the DHS is proposing trailer bill language which enables them to implement utilization controls through the establishment of guidelines, protocols, algorithms, or criteria for drugs, medical supplies, durable medical equipment and enteral formulae. The department shall publish the guidelines, protocols, algorithms, or criteria in the pharmacy and medical provider manuals. In addition, the DHS will issue pharmacy providers written notice of changes. **Further, the DHS intends to make these actions exempt from requirements of the Administrative Procedures Act.**

Background—(4) Face-to-Face Interventions: This would be a pilot project on face-to-face discussions between a pharmacist expert and prescribers on rational drug therapy as required by federal law.

Governor's May Revision: The May Revision **is requesting $496,000 ($169,000 General Fund) for four positions**—one Medical Consultant I, one Pharmaceutical Consultant, and two Research Analyst IIs to craft and implement these proposals. **The DHS assumes savings from the Step-Care Drug Therapy Program of $1.8 million ($900,000 General Fund) in the budget year,** and $16 million ($8 million General Fund) annualized.

With respect to the other three items combined (no separate estimate for each)—Direct Prescriber Communications, Enhanced Education and the Face-to-Face interventions,--total budget year savings are assumed to be $500,000 ($250,000 General Fund) in the budget year. Out year savings increase to as high as $16 million ($8 million General Fund) for 2005-06. **They contend that savings for these items rely on the specific reaction of prescribers to the various educational interventions, so savings will vary. However, the DHS does believe that educational programs could save as much as one-half to one percent of total expenditures annually, upon full implementation (savings would phase in over time.)**

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please **explain the DHS' proposal by each component piece, as well as the need for the positions.**
- 2. Please **explain the trailer bill language** and how it would be implemented.

Budget Issue: Does the Subcommittee **want to modify the proposal?**

13. Capitate Health Plans to Treat HIV/AIDS to Medi-Cal Managed Care Plans

Governor's May Revision: Medi-Cal Managed Care currently operates in 22 counties in California, and the contracts vary in coverage requirements for certain drugs. **The May Revision is proposing to capitate health plans for services that are currently excluded—drugs to treat HIV/AIDS which have been approved by the Federal Drug Administration before March 1, 2003 (i.e., this proposal excludes Fuzeon intentionally from the capitation proposal).**

The DHS assumes savings of just over $100,000 (General Fund) in the budget year, assuming a January 1, 2004 implementation date. Savings would be based on the total expenditures for these drugs which is estimated to be $8.7 million (based on paid claims for calendar year 2001). If capitation were paid at 95 percent of the fee-for-service level, savings would be $218,000 (General Fund) annually.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please briefly explain the proposal.
- **2.** Will access to drugs for individuals with HIV/AIDS be affected at all by this proposal?

Budget Issue: Does the Subcommittee **want to adopt or modify the May Revision?**

14. Change Reimbursement Methodology for Durable Medical Equipment (DME) *(See Hand Out)*

Background: For the most part, DME providers are reimbursed at levels below the Medicare rate. ***Currently, prices are set for Durable Medical Equipment (DME) through a listing specified in regulation*. According to the DHS, this is a rigid and overly bureaucratic method that denies the DHS flexibility to reduce prices quickly as products on the market change.**

Bureau of State Audits (BSA): The Bureau of State Audits conducted an audit of the DHS purchasing and contracting practices for DME, medical supplies, and hearing aids under Medi-Cal. Among other things, the BSA concluded that the DHS:

- Has ineffective cost control procedures for "unlisted" items;
- Lacks written policy or other requirements defining how often it should update maximum reimbursement rates for DME, or hearing aid tools; and
- Lacks authority and procedures to be used for ensuring the lowest possible price for items that meet the medical needs of the Medi-Cal recipient.

Among other things, the BSA recommended that the DHS seek legislation to remove prices for DME and hearing aids from regulations so that the DHS can become more responsive to changes in prices.

Governor's May Revision (See Hand Out): As an ***alternative*** **to the 15 percent rate reduction**, **the DHS is proposing to make targeted reductions and changes to the reimbursement methodology for DME. As a result, the DHS would have the authority to utilize and/or change this methodology for the DME rates. This requires trailer bill language to implement.**

Generally, these changes include establishing a:

- List of covered DME services and maximum allowable reimbursement rates.
- Methodology and reimbursement rate for DME, except wheelchairs, as the lesser of an amount that does not exceed 80 percent of the Medicare or "acquisition cost" negotiated via the contracting process plus a 40% markup.
- Methodology and reimbursement rate for wheelchairs as the lesser of an amount that does not exceed 100 percent of Medicare or acquisition cost negotiated via the contracting process, plus a 40% markup.
- Methodology and reimbursement rate for codes with **no maximum allowable rate** as the "acquisition cost" negotiated via the contracting process plus a 40 %markup or the lesser of the actual acquisition cost plus a 40 percent markup or 80 percent of the manufacturer's suggested retail purchase price.
- Methodology and reimbursement rate for supplies and accessories as the actual acquisition cost plus a 23 percent markup.

The DHS is requesting an increase of $89,000 ($44,000 General Fund) to support one position—Research Specialist II—for this purpose.

The DHS states that savings of $3.2 million ($1.6 million General Fund) in local assistance can be achieved in the budget year through this change, and that annual savings are $13.4 million ($6.7 million General Fund). **The DHS notes that it will take them one month or more to process the new payment rates after the rates have been determined.**

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please **briefly describe the proposal *and* use examples** to illustrate the proposed changes from what presently occurs.
- **2.** It is likely that Medi-Cal recipients would experience decreased access to services because of this change?

Budget Issue: Does the Subcommittee **want to modify the May Revision?**

15. Change Reimbursement Methodology for Blood Factor Products *(See Hand Out)*

Background: The ***current methodology*** of payment **is for a manual claim submission with an invoice attachment for the blood factor product being supplied to the patient. This invoice amount is then compared to the billed amount and a 1% markup is allowed to cover the cost of services.**

Currently, **the State Controller's Office (SCO) reviews each claim for blood factors and calculates the allowed payment amount.** This function started several years ago after an investigation of a large provider and has been going on ever since. **This activity is time consuming and the accuracy and/or appropriateness of the invoiced amount is not documented.**

Governor's May Revision (See Hand Out): The DHS **is proposing to (1) adopt a new methodology for provider payments of Blood Factor products, and (2) automate the claims processing and rebate activities. This proposal requires trailer bill legislation.**

Among other things, the department will be using the Average Selling Price (ASP) in lieu of the Average Wholesale Price (AWP). The DHS contends that the utilization of the ASP as provided by the manufacturer pursuant to contract would allow the DHS to better control costs.

The DHS states that local assistance savings of $2.450 million ($1.225 million General Fund) can be achieved from these changes. The DHS states that under their proposal, the following benefits would accrue:

- Provides for more accurate provider reimbursement.
- Uses a real market acquisition cost in reimbursement methodology.
- The Average Selling Price (ASP) is not as easily manipulated in comparison to the Average Wholesale Price (AWP).
- Automates claims processing and rebate activities.
- Provides the DHS with comparative data for use in rebate contracting.
- Provides for enhanced rebate collection.
- Provides for accurate tracking of patient utilization.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please **briefly explain the concerns there are with the existing payment method**, as well as the manual claims processing.
- **2.** Please briefly describe the Administration's proposal using examples to illustrate how reimbursements would be changed.
- **3.** Would Medi-Cal recipient access to Blood Factor products be placed in jeopardy due to these proposed changes? If not, why not?
- **4.** Please briefly walk through the proposed trailer bill language.

Budget Issue: Does the Subcommittee **want to adopt the proposal?**

16. Medi-Cal Program Limits on Certain Laboratory Services

Background: The DHS states that there have numerous instances of the fraudulent provision of laboratory services in both the Medi-Cal and Medicare programs. **The DHS sites several laboratories by name where there have been fraudulent billings for medically *unnecessary* laboratory tests, including cholesterol and blood serum iron tests.** Other laboratories are submitting claims for drug screening tests that were done by the use of a single procedure with a single result statement and billing Medicare 25 to 30 times per patient.

Governor's May Revision: In order to mitigate over-utilization and the potential for abusive billing, the DHS proposes **to place limits on the number of laboratory tests that could be claimed without prior authorization under the Medi-Cal Program.** The DHS states that they do ***not*** need any trailer bill legislation to implement this proposal.

Specifically, selected laboratory services would be subject to a frequency limitation for services occurring within a set period of time. Once that frequency of service has been reached, additional laboratory services would be subject to prior authorization for the determination of medical necessity. A September, 2003 implementation date is assumed.

The DHS assumes that *savings of about $10.6 million ($5.3 million General Fund)* in local assistance can be achieved by implementing these controls.

In addition, the DHS *is requesting an increase of (1) $82,000 ($41,000 General Fund) to fund one position* to perform very detailed work at the laboratory procedure code level, and *(2)* $2.4 million ($805,000 General Fund) to fund changes to be done by the Fiscal Intermediary (EDS).

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please **briefly describe** how the limits would work.
- **2.** Specifically, how would Medi-Cal recipients be affected by this change?
- **3.** How long would it take to turn-around a treatment authorization request for services?

Budget Issue: Does the Subcommittee **want to adopt the proposal?**

17. Reduction and Monitoring of Excessive Administrative Cost of Contractors *(See Hand Out)*

Background: California **HMOs are required to control the administrative cost of their operations to reasonable levels.** Under Knox-Keene regulations (Title 22) enforced by the Department of Managed Health Care, **HMO plans that have been operational in excess of five years and incur administrative costs at or below fifteen percent of their total revenue are presumed to be in compliance with the DMHC's requirements.** Plans that incur administrative costs in excess of this amount may be called upon to demonstrate that their costs are not excessive or be required to take corrective actions to reduce their administrative costs to an acceptable level. The majority of DHS' Medi-Cal Managed Care contractors are Knox-Keene health care plans.

The DHS Two-Plan Model currently has a regulation that requires contracting health care plans to include as part of their administrative cost the pro-rata amount of administrative costs under their capitated sub-contracting providers. **This part of the regulation while initially based on Knox-Keene regulations, provides that contracting health plans should include in their administrative cost, the cost of delegated administration to sub-contracting entities. The DHS states that up to this point it has not been necessary to vigorously pursue excessive administrative costs because the use of sub-contracting entities was not a widely-used model. However, the DHS wants to change this approach.**

Governor's May Revision (See Hand Out): The May Revision proposes to enhance its on-going monitoring efforts by redirecting some existing staff to force HMO plans to either justify administrative costs in excess of 15 percent or be subject to potential recovery of funds and/or subject to rate adjustments. **The DHS anticipates that savings of about $39 million (19.5 million General Fund) are achievable in 2004-05, but no savings for 2003-04.**

The DHS is proposing trailer bill language in order to achieve more direct statutory authority for this effort, including obtaining recoveries if excessive administrative costs are found.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please **briefly explain your proposal**, including the trailer bill language.
- **2.** Why can't some modicum of savings be achieved in 2003-04?

Budget Issue: Does the **Subcommittee want to adopt the proposal?**

18. DHS Staff for Personal Injury Recovery Program

Background: **The Personal Injury Recovery Program identifies and recovers health care services expended on behalf of Medi-Cal beneficiaries when a third party is liable,** ensuring that Medi-Cal is the payer of last resort. As required by law, attorneys, county welfare agencies, and insurance companies must notify the department of tort actions involving a Medi-Cal beneficiary. **DHS staff review Medi-Cal expenditures paid for injury-related services, then file liens for recovery against any settlement, judgement or award.**

Governor's May Revision: The May Revision requests **an increase of $358,000 ($90,000** General Fund) to fund three positions—two Tax Compliance Representatives and one Program Technician II. **Of this amount, $160,000 is for contract services related to information technology services. Further, the DHS is proposing trailer bill language to make changes to the Medi-Cal recovery process.**

The positions are to be used to augment the recovery of revenue due the state under a new state mandate requiring auto insurance carriers to make their records available to the Medi-Cal Program. According to the DHS, this mandate will increase the number of Personal Injury cases the DHS will initiate recovery against. **The DHS estimates that $1.4 million (total funds) can be achieved annually from these positions.**

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please **provide a brief description of the proposal.**
- **2.** Please describe the purpose of the trailer bill language.

Budget Issue: Does the Subcommittee **want to adopt or modify the May Revision?**

19. Lawsuit—Conlan vs Director Bonta' *(See Hand Out—language)*

Background—Conlan Decision: Medi-Cal recipients who incur out-of-pocket expenses for services that are rendered by a Medi-Cal enrolled provide, and that are reimbursable services under the Medi-Cal Program, are required to seek reimbursement for their out-of-pocket expenses from the provider who rendered the services (Section 140019.3 of W&I Code). **Under existing Medi-Cal authority, a provider may wait until a claim for reimbursement submitted to Medi-Cal is adjudicated and paid before reimbursing the recipient.**

According to the DHS, in the **Conlan v. Bonta' decision (Conlan Decision), the Appellate Court held that the state must establish a *reasonable* procedure by which recipients may obtain prompt reimbursement for covered services for which they paid during the three months prior to applying for Medi-Cal coverage. The court further found that the recipient should not be required to wait until the provider submits and is reimbursed for a claim for services rendered, before being reimbursed.**

Governor's May Revision: The May Revision proposes **an increase of $2.1 million ($1 million General Fund) to fund 17 new state positions at the DHS, and to fund 7 positions at the Department of Social Services. In addition, the DHS includes increases in the Medi-Cal local assistance budget for additional contract work to be performed by both Fiscal Intermediaries (EDS and Delta Dental). The DHS states that the purpose of these additional resource requests is to address issues in the Conlan Decision.**

The state positions would be located within the following areas:

- **Performance & Change Management Branch**—two Associate Governmental Program Analysts;
- **Headquarters Management Branch**—one Associate Government Program Analyst;
- **Administrative Branch**—two Accounting Technicians and 8 Accounting Trainees;
- **Medi-Cal Benefits Branch**—one Associate Governmental Program Analyst;
- **Medi-Cal Dental Services Branch**—three Associate Governmental Program Analysts; and
- **Department of Social Services—five Administrative Law Judges and two Office Technicians.**

The Administration is proposing trailer bill language to modify Section 14019.3 of Welfare and Institutions Code to, among other things, (1) clarify that reimbursement is due if it is within a 90-day period of application to Medi-Cal, (2) clarify that the service was a Medi-Cal covered service, (3) clarify that the provider was enrolled in Medi-Cal, and (4) provides the DHS with the ability to withhold provider payments or suspend a provider from participating in Medi-Cal, if they do not meet certain conditions.

Legislative Analyst Office Comment: The LAO states that the **DHS request includes full and immediate staffing to address a workload that will actually phase in more gradually over the budget year.** They note that the DHS has not even yet submitted their plan to the court for approval. **Therefore, the LAO is recommending to budget the requested DHS and DSS positions at 75 percent of the requested funding level for savings of $518,000 ($257,000 General Fund) in the budget year. Full funding for the Fiscal Intermediary is recommended to continue.**

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please **describe the Conlan Decision and workload of the positions.**
- **2.** What is now being done up-front with providers and recipients to mitigate the problem brought to the Court in the first place?
- **3.** Please **step through the proposed trailer bill language.**

Budget Issue: Does the **Subcommittee want to adopt the LAO recommendation for both the DHS and DSS (conforming action)?**

20. Federal Fiscal Relief for States—Placeholder

Background and Senate 1054: On May 15th, 2003, the Senate overwhelmingly approved its fiscal relief amendment by a vote of 95 to 3. **The $20 billion package would provide $10 billion to temporarily increase the federal match for the Medicaid Program and a $10 billion grant to state and local governments**. States would receive $6 billion in grant funds and local governments $4 billion to be used for general purposes, including education and job training, **health and social services**, transportation and infrastructure, law enforcement and public safety, or other essential governmental services.

California would receive an estimated $2.4 billion from this aid package. **This would include $1.3 billion in additional Medicaid dollars,** $690 million in grant funds to the state, and $470 million in grants to local government.

Budget Issue: Does the Subcommittee want **to assume receipt of some portion of federal fiscal relief?**

C. DEPARTMENT OF MENTAL HEALTH *(Discussion Items)*

COMMUNITY-BASED MENTAL HEALTH ISSUES

1. Eliminate Community Services Activities

Governor's May Revision: The May Revision proposes a reduction of **over $2 million (General Fund) from a variety of community services activities, including areas that significantly affect consumer and family involvement in participating in mental health policy, as well as the provision of some direct services. The activities include the following:**

- $416,000 Sacramento County pursuant to SB 840, Statutes of 1991
- $307,575 13 counties which use these funds to draw down federal rehabilitation funds
- $250,000 CA Institute of Mental Health for training of local mental health staff
- $227,518 CA Network of Mental Health Clinics
- $334,650 National Alliance for the Mentally Ill-California
- $30,800 CA Association of Local Mental Health Boards and Commissions
- $47,036 NA Association of Mental Health Program Directors dues payment
- $15,000 WICHE dues (data analysis and collection)
- $80,000 San Joaquin County for training for the CA Association of Mental Health Boards and commissions and county Olmstead training
- $15,000 San Joaquin to provide training and technical assistance on Therapeutic Behavioral Services
- $45,000 CA Mental Health Directors Association
- $40,000 San Mateo County for development of quality indicator data
- $190,000 Santa Cruz County to facilitate automation of the annual county cost reports
- $5,000 Older Adult Mental Health System of Care Conference
- $24,381 Sacramento County to partially fund a psychiatric consultant on children's mental health issues
- $2,040 Governor's Homeless Conference

Subcommittee Staff Recommendation: The Subcommittee has received numerous letters regarding these reductions which have expressed considerable concern with these reductions. These funds are being utilized for a wide variety of functions but primarily to (1) provide support and education, (2) increase community awareness and understanding of mental health issues, (3) facilitate family-involvement, (4) encourage public participation in the development of mental health policy, and (5) data analysis to improve the quality of services offered.

It is recommended to reject this proposal, except for the elimination of the $2,040 for the Governor's Homeless Conference. This action would conform with the Assembly.

Budget Issue: Does the Subcommittee **want to restore funding to all of the projects, except for the $2,040** slated for the Governor's Homeless Conference?

2. Mental Health Managed Care—ISSUES "A" through "C"

Overall Background—Overview of Mental Health Managed Care: Implementation of Medi-Cal Mental Health Managed Care has included the consolidation of Medi-Cal psychiatric inpatient hospital services ("Phase I"), which occurred in January 1995 and the consolidation of Medi-Cal specialty mental health services ("Phase II"), which occurred from November 1997 through June 1998. **These two phases of implementation consolidated the two existing Medi-Cal mental health programs (Short-Doyle and Fee-For-Service) into one service delivery system. This consolidation required a Medicaid Waiver ("freedom of choice") and as such, the approval of the federal government (i.e., HCFA, now the Centers on Medicare and Medicaid—CMS).**

Under this delivery system, psychiatric inpatient hospital services and outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists, and some nursing services**, became the responsibility of a single entity, the Mental Health Plan (MHP) in each county. Medi-Cal recipients *must* obtain services through the MHP.**

The Waiver promotes plan improvement in three significant areas—access, quality and cost-effectiveness/neutrality.

Under this model, **MHPs generally are at risk for the state matching funds for services provided to Medi-Cal recipients and claim federal matching funds on a cost or negotiated rate basis. An annual state General Fund allocation is also provided to the MHP's.**

Based on the most recent estimate of expenditure data for 2001-02, of California's state share of cost for Mental Health Managed Care, County MHPs provided a 46 percent match while the state provided a 54 percent match. (Adding these two funding sources together equates to 100 percent of the state's match in order to draw down the federal Medicaid funds.)

The DMH is responsible for monitoring and oversight activities of the MHPs to ensure quality of care and to comply with federal and state requirements.

Federal Approval of Waiver Granted: According to the DMH, **California received federal CMS approval of the revised Waiver as of late April.**

ISSUE "A"—Clarification of Trailer Bill Language (Hand Out) for Emergency Regulation Authority

Background—Emergency Regulation Authority Is Never Ending: Effective **November 1, 1997,** the DMH adopted emergency regulations for Medi-Cal Mental Health Managed Care as provided for in Section 5775 of Welfare and Institutions Code. **However, this authority was never intended to be on-going.**

Since this time, the DMH has obtained authority to continue the emergency regulations through annual Budget Act Language, including language adopted in 1998, 1999, 2000, 2001 and 2002. This authority will expire as of June 30, 2003, unless action is taken to extend this authority. The Governor's January 2003 budget proposed to continue this practice by proposing the same Budget Bill Language to continue the emergency regulations.

The DMH has **had two public comment periods on the emergency regulations—November 1997 to January 1998, and November-December 1999.** According to the DMH, extensive public comment was received.

Subcommittee's Prior Action: In the March 10th hearing, **the Subcommittee (1) deleted the proposed Budget Bill Language and (2) adopted "placeholder" trailer bill language which would grant the DMH only one more year of emergency regulation authority.**

Subcommittee Staff Comment: Proposed **trailer bill language has been drafted and is contained in the Hand Out package.** ***It is recommended to adopt this language in lieu of the placeholder language.*** **(The prior action of deleting the Budget Bill Language would stand.)**

Budget Issue: Does the Subcommittee **want to adopt the proposed trailer bill language?**

ISSUE "B"—Implementation of New Federal Regulations for Waiver

Background—New Federal Regulations for Waiver: As discussed above, California's Medi-Cal Mental Health Managed Care Program operates under a federal Waiver. Our Waiver enables a County Mental Health Plan (MHPs) to limit client access to a specific pool of services and practitioners. The Waiver promotes MHP improvement in three significant areas—access, quality, and cost containment/neutrality.

New federal managed care regulations were issued in June 2002 and must be implemented by the state and MHPs by August 13, 2003. According to the DMH, the new regulations require significant changes in the operation of the program.

Among other things, the regulations would require:

- The DMH must arrange for **annual "External Quality Reviews" (EQRs)** of the quality outcomes and timeliness of access to services covered by **each MHP** (56 MHPs—there are two MHPs that cover two counties);

- The methodology used to **reimburse the MHPs must be validated annually by a qualified actuary**. The DMH notes that **the actuarial studies may result in the need to revise current methods since the method currently used for distributing state General Fund support to the MHPs is *not* actuarially determined.**
- **The County MHPs will be required to (a)** establish advance directive systems, **(b)** establish formal compliance plans and systems, **(c)** finalize and distribute informational materials, **(d)** comply with new administrative requirements related to provider contracts, **(e)** maintain additional documentation of the adequacy of the MHP's provider networks, **(f)**adopt formal practice guidelines, and **(g)** establish a more complex grievance and appeal system.

Generally, the state has three options for meeting the requirements of the regulations. We can either (1) fully comply, (2) request Waivers for certain provisions, or (3) restructure the existing program to meet all of the requirements.

Governor's January Budget: The Governor's January budget proposed **an increase of $6.2 million ($1.7 million General Fund** and $4.5 million in reimbursements from the DHS—federal Medicaid funds) **and a two-year limited-term Associate Mental Health Specialist position to support federally required External Quality Reviews (EQRs)** of the County Mental Health Plans (MPHs) **and related activities** to ensure that the program is brought into compliance with new federal regulations.

Governor's May Revision: The May Revision **proposes a net reduction of $5 million** ($1.250 million General Fund and $3.750 million in Reimbursements) **due to changes in the federal regulations that came forth in late January.** Generally, these revised federal regulations provide the DMH with flexibility in performing compliance reviews as well as other components. It also means that the External Quality Reviews (EQRs) can be conducted on a more gradual basis—six a year.

Therefore, the DMH is requesting **a *net* increase of $1.225 million** ($463,000 General Fund and $762,000 in Reimbursements) for the budget year. **Of this net amount (1)**$600,000 is for the EQRs, **(2)** $500,000 is for client information and materials, **(3)** $50,000 is for a contract to conduct an actuarial analysis, and **(4)** $75,000 is for a two-year limited-term Associate Mental Health position and related operating expenses.

The DMH states that the requested two-year limited-term position is needed to review and revise existing state and MHP systems to comply with the new regulations. Specifically, it would be used to review current state regulations, MHP contracts, DMH Letters to Counties and Information Notices, Waiver documents and other materials for compliance with the new federal regulations.

Subcommittee Staff Recommendation: Subcommittee staff **recommends (1)** approval of the Governor's May Revision to reduce by $5 million ($1.250 million General Fund and $3.750 million in Reimbursements), and **(2)** in lieu of the new position, re-direct a position from within the DMH for this purpose for additional savings of $75,000 ($37,500 General Fund).

It is recognized that this is an important function that needs to be completed; however due to implementation timeframes it is unlikely that the DMH would be able to hire someone and have

the activities accomplished. Further, DMH staff is working on this issue now and therefore, have been redirecting resources already for this purpose.

Budget Issue: Does the **Subcommittee want to (1) adopt the Governor's May Revision to reduce by $5 million ($1.250 million General Fund), and (2) delete the requested position for additional savings of $75,000 ($37,500 General Fund)?**

ISSUE "C"—Governor's Proposed Reduction in Funding of Waiver

Background—State & County Realignment Funds Used to Draw Federal Match: As discussed above, the state's Mental Health Managed Care Program operates under a federal Waiver whereby County Mental Health Plans (MHPs) are responsible for the provision of public mental health services, including those for Medi-Cal recipients.

An annual state General Fund allocation is provided to County MHPs, though counties also use a substantial amount of County Realignment funds—Mental Health Subaccount-- to draw down federal matching dollars.

Based on the most recent estimate of expenditure data for 2001-02, of California's state share of cost for Mental Health Managed Care, County MHPs provided a 46 percent match while the state provided a 54 percent match. (Adding these two funding sources together equates to 100 percent of the state's match in order to draw down the federal Medicaid funds.)

State General Fund Allocation: **The state General Fund allocation is usually updated each fiscal year to reflect adjustments as contained in Chapter 633, Statutes of 1994 (AB 757, Polanco). These adjustments have typically included, changes in the number of eligibles served, factors pertaining to changes to the consumer price index (CPI)for medical services, and other relevant cost items.**

However, **the state's allocation is contingent upon appropriation through the annual Budget Act. As such in more difficult fiscal years, state General Fund support has *not* been provided for the medical CPI, or the base level of funding has been proposed for reduction (such as this year).**

Governor's May Revision: The May Revision proposes a total state General Fund appropriation of $212 million (General Fund) for allocation to the County MHPs to assist in funding the Waiver Program. **This reflects a *net* increase of $4.9 million (General Fund)** in the amount the state provides to the counties for Mental Health Managed Care**. It should also be noted that the medical CPI is *not* being funded and has not been funded since the Budget Act of 2000**. **This equates to a loss of $13.4 million ($6.7 million General Fund) to the County MHPs.**

This net decrease consists of the following proposed *key* adjustments:

- **Assumes a 10 percent reduction to the base County allocation amount, effective October 1, 2003.** **(The Administration is referring to this as a ten percent Medi-Cal provider rate reduction; however, it is a reduction to counties.)**

- **No adjustment for the medical Consumer Price Index (CPI) was provided. According to the DMH, it would be about 3.4 percent in the budget year for an expenditure of $13.4 million ($6.7 million General Fund). It should be noted that the medical CPI has not been funded for Mental Health Managed Care since the Budget Act of 2000.**

- **Makes a series of technical adjustments related to caseload.**

Subcommittee Staff Comment and Recommendation: The proposed reduction will likely result in County MHPs serving fewer individuals and having difficulty in meeting statutory and contractual responsibilities related to the provision of Medi-Cal Mental Health Managed Care services. Both the short-term and long-term effect of this action is to cost shift mental health services more to the counties.

It is recommended **to reject the 10 percent reduction to the base County allocation amount, and to adopt all other technical adjustments regarding caseload and deferral of the medical CPI.**

Budget Issue: Does the Subcommittee **want to reject the 10 percent rate reduction and adopt all other technical adjustments regarding caseload and deferral of the medical CPI?**

3. Second Level Treatment Authorization Request Appeals.

Background: Existing state regulation (Title 9, Section 1850.305) provides that **a psychiatric hospital may file a second level TAR appeal when payment issues have not been resolved at the first level appeal (between the hospital and a County Mental Health Plan).**

Typically, a second level TAR appeal involves disagreements between a hospital (non-county owned or operated facility) and a County Mental Health Plan regarding the number of bed days the county will reimburse. For example, a hospital claims 15 days of inpatient services for a particular client and the County Mental Health Plan will only approve 10 days. As such, the hospital appeals the additional 5 days to the state. The state can either agree or disagree with the hospital. According to DMH statistics, the DMH agrees with County

Mental Health Plans about 88 percent of the time.

It should also be noted, that the DMH's role in the second level TAR appeals process has inserted the department into judicial disputes between hospitals and County Mental Health Plans. According to the DMH, 29 lawsuits have been filed in this area.

Governor's Mid-Year Reduction and Proposed January Budget: The Administration proposed to eliminate the second level Treatment Authorization Request (TAR) appeals process for savings of $64,000 General Fund in 2002-03 and savings of $126,000 (General Fund) in 2003-04. The savings comes from the elimination of two state positions. **The Legislature denied the request for the Mid-Year Reduction.**

No trailer bill language has been proposed for this action.

Constituency Concerns: County MHPs are concerned about this proposal because hospitals who want to appeal a County MHP denial of payment can go directly to the courts, and the DMH would no longer be involved in the case.

Subcommittee Staff Comment and Recommendation: The Administration's proposal continues the Administration's direction to further reduce the state's role in providing oversight of mental health services. In this case, oversight of inpatient hospital psychiatric services. **This is really a policy area that needs to be clarified more, rather than a fiscal, budgetary issue. Broader policy issues exist that affect the provision of inpatient psychiatric services and the payment for them.**

It is therefore recommended to (1) reject the Administration's proposal to eliminate the existing second level TAR appeals process, and (2) adopt placeholder trailer bill language to require any hospital losing its second level appeal be required to reimburse the DMH for its cost (less the federal match portion).

Budget Issue: Does the Subcommittee want to **(1)** reject the Administration's proposal and retain the existing process and position, and **(2)** adopt placeholder trailer bill language to require any hospital losing its second level appeal be required to reimburse the DMH for its total cost of processing the appeal, less the federal match portion.

STATE HOSPITAL ISSUES

1. State Hospital Patient Population & Operating Expenses Adjustments, and Proposed Trailer Bill Language (See Hand Out)

Subcommittee's Prior Action: In a prior hearing, the Subcommittee heard from the Legislative Analyst's Office that the **Governor's January budget request** for the State Hospital population and corresponding operating expenses **was significantly over budgeted**. As such, the Subcommittee deferred action pending further discussions between the LAO and DMH regarding potential expenditures and pending May Revision caseload adjustments.

Governor's May Revision: The **May Revision proposes a population of 4,457 patients** for 2003-04 (as of June 30, 2004) at the four State Hospitals -- Napa, Metropolitan, Patton, and Atascadero. **Of this population**, **almost 85 percent of the beds are designated for penal code-related patients. This caseload adjustment reflects a *reduction* in the estimated caseload of 183 patients as compared to the Governor's January budget.**

The May Revision reflects a ***net decrease*** **of $17.1 million ($11.5 million General Fund,** $6.8 million in County Realignment Funds, $119,000 in Reimbursements from the CA Department of Corrections, and an increase of $1.3 million in reimbursements from the CA Department of Youth Authority) due to the following adjustments:

- Decrease of 90 county-purchased beds;
- Increase of 34 penal code beds;

- Decrease of 213 positions, including level-of-care and non-level-of-care positions; and
- Reduction of $1.5 million from operating expenses and equipment.

It should also be noted that a net decrease of $6 million (decrease of $8.2 million General Fund and an increase of $2.2 million in County Realignment Funds) is being done for the current-year (2002-03) due to a decrease of 100 penal code beds (assumes a population of 4,425 patients as of June 30, 2003).

Governor's May Revision—Proposed Trailer Bill Legislation: The DMH **is proposing to add a new Section 1026.2(m) to the Penal Code related to Not Guilty by Reason of Insanity (NGI) acquittees as follows**:

> (m) This subdivision shall only apply to persons who, at the time of the petition or recommendation for restoration of sanity, are subject to a term of imprisonment with prison time remaining to serve or are subject to imposition of a previously stayed sentence to a term of imprisonment. When a person described in this subdivision petitions or is recommended for restoration of sanity, the person shall not be placed in a forensic conditional release program for one year, and a finding of restoration of sanity may be made without the person being in a forensic conditional release program for one year. If a finding of restoration of sanity is made, the person shall be transferred to the custody of the California Department of Corrections to serve the term of imprisonment remaining or shall be transferred to the appropriate court for imposition of the sentence which is pending, whichever is applicable.

According to the DMH, this proposed change would provide that NGIs with "dual-hold" status in a State Hospital or being transferred to a State Hospital from court or prison would be treated in the State Hospital until restored to sanity. Once stabilized, the individual would be **transferred to prison to serve their terms for the crimes** for which they were convicted or returned to court for the imposition of any pending sentence that had been stayed during treatment.

Currently, individuals convicted of violent felonies who have a simultaneous or subsequent NGI acquittal for another felony may be sent to State Hospitals instead of prison at the discretion of the court. **The mental health system is rarely consulted prior to such decisions.**

As such, the DMH contends that some individuals may spend many years in a State Hospital and will not serve prison time for their felony convictions even though their mental health has been restored and their condition is stabilized. Further they note that these indefinite State Hospital terms represent an inappropriate and costly misuse of State Hospital beds and treatment resources and precludes punishment for crimes for which they were convicted.

Subcommittee Staff Recommendation: Both the Subcommittee staff and LAO concur with the May Revision caseload and operating expenditure adjustments.

Subcommittee Request and Questions: The Subcommittee has requested the DMH and LAO to respond to the following questions:

- **1. DMH**, Please briefly explain the **budget year adjustments** regarding patient population and operating expenses.
- **2. DMH,** Please **briefly explain the need for the proposed trailer bill language.**
- **3. LAO, Does there need to be technical adjustment to the Reimbursements paid to the DMH by the CA Department of Corrections (CDC) to reflect adjustments made in the CDC budget?**

Budget Issue: Does the **Subcommittee want to adopt both the Governor's May Revision** for revised patient caseload and OE&E expenditures, **and** the proposed trailer bill language which amends Section 1026.2(m) of the Penal Code?

2. Conditional Release Program Adjustments & the Sexually Violent Predator Community Services Proposal

Background—What is CONREP: Existing statute provides for the **Conditional Release Program (CONREP)** and mandates that the **DMH be responsible for the community treatment and supervision of judicially committed patents, including Mentally Disordered Offenders (MDOs) and Sexually Violent Predators (SVPs).**

CONREP, in operation since 1986, provides outpatient services to patients in the community and hospital liaison visits to patients continuing their inpatient treatment at State Hospitals who may eventually be admitted into CONREP. **CONREP service are provided throughout the state and are either county-operated *or* private/non-profit operated under contract to the DMH. The goal of CONREP is to ensure greater public protection in California communities via a system of mental health assessment, treatment, and supervision to persons placed on outpatient status.**

Funding for CONREP services is based on the number of outpatient cases and applicable State Hospital patients, and an average cost per patient for services.

The DMH states that existing CONREP providers, except for four, have opted out of providing community treatment services to SVPs.

Background—Imminent Sexually Violent Predator Release: In an April 15, 2003 letter to the Joint Legislative Budget Committee (Senator Chesbro, Chair), the Administration requested to transfer $76,000 in additional appropriation authority for CONREP for contract expenditures related to the first release of an SVP from a State Hospital to the community. **This current year transfer was approved by the Joint Legislative Budget Committee with noted reservations (to be discussed below).**

This $76,000 transfer, along with the availability of some unexpended funds, provided about $264,000 for the DMH to contract with Liberty Healthcare Corporation to provide supervision and treatment services in the current year (2002-03) for an SVP to be released into the community.

Specifically, the DMH notes that Santa Clara County granted a conditional release which will result in the release of an SVP into the community, and that Contra Costa County may soon be compelled to release an SVP as well. The DMH states that both of these patients are to be returned to their committing counties to live. **As such, the DMH contends that these court actions necessitate the funding of CONREP service plans for supervision and treatment, including living costs.**

Governor's May Revision: As previously noted, all of the DMH's current CONREP providers, **except for four**, have opted out of providing community treatment services to SVPs. As such, the DMH wants to continue to **contract with Liberty Healthcare for the 54 counties that will not serve SVPs.**

The May Revision is requesting an increase of $2 million (General Fund) for increased CONREP expenditures due to:

- An increase of **8 *non-SVP* patients for a full year cost of $163,000 (General Fund)**;
- An increase of **8 *non-SVP* patients for a half-year cost of $82,000 (General Fund)**; and
- An increase in costs **associated with establishing a community treatment program for Sexually Violent Predators (SVPs) expected to be released from the State Hospitals and court-ordered into CONREP. Specifically, the estimated cost for CONREP services for five SVP patients receiving community services for the budget year is almost $1.9 million. This is discussed below:**

The proposed May Revision adjustment for the Liberty Healthcare contract assumes the following:

• Central office operation		$495,000
• Outpatient case managers	(3 clients at $170,000 each)	$510,000
• Treatment costs for clients	(3 clients at $24,000 each)	$72,000
• Living costs for clients	(3 clients at $30,000 each)	$90,000
• Miscellaneous contract costs	(3 clients at $14,000 each)	$42,000
• **Subtotal**		**$1.2 million**
• DMH proposed **off-set** due to less funding in CONREP		($117,000)

The proposed **San Diego County costs** include the following:

• Personnel and operating expenditures (1 client)	$302,000
• Treatment costs (1 client)	$17,000
• Living costs (1 client)	$35,000
• **Subtotal**	**$354,000**

The proposed **Los Angeles County—Gateways** costs include the following:

• Personnel and operating expenditures (1 client)	$255,000
• Treatment costs (1 client)	$35,000
• Living costs (1 client)	$36,000
• **Subtotal**	**$326,000**

The DMH states that all of the above SVP programs will use the **community containment model**, developed by the US Department of Justice. This model combines the use of supervision and monitoring tools, mental health treatment and victim advocacy.

Legislative Analyst's Office Recommendation: The LAO is recommending **to approve the $245,000 increase in the regular CONREP Program but to deny the Administration's May Revision request regarding the SVP portion and instead, craft a different approach whereby the CA Department of Corrections can supervise CONREP clients. According to the LAO, savings of $1.8 million(General Fund) can be achieved by using CDC personnel.**

Subcommittee Request and Questions: The Subcommittee has requested the DMH and LAO to respond to the following questions:

- **1. DMH, Please present your proposal.**
- **2. LAO, Please present your recommendation.**

Subcommittee Staff Recommendation: Does the Subcommittee **want to modify the Administration's proposal?**